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GOVERNMENT DOCUMENTS COLLECTION

AIDS NEWSLETTER

a monthly publication from the
Massachusetts Department of Public Health/Boston Department of Health and Hospitals

Vol. 6 **January, 1990** **No. 1**

UPDATE

During December, a total of seventy-eight new AIDS cases were reported to the Massachusetts AIDS Surveillance Program.

CUMULATIVE AIDS CASES BY INSTITUTION AND YEAR OF REPORT

Institution	as of 01/01/89		as of 01/01/90	
	No.	(%)	No.	(%)
Atlanticare Medical Center	8	(0.4)	10	(0.4)
Baystate Medical Center	57	(2.8)	79	(2.8)
Berkshire Medical Center	11	(0.5)	17	(0.6)
Beth Israel Hospital	159	(7.9)	228	(8.2)
Boston City Hospital	180	(9.0)	263	(9.4)
Brigham & Women's Hospital	139	(6.9)	192	(6.9)
Cambridge Hospital	12	(0.6)	18	(0.6)
Cape Cod Hospital	13	(0.6)	18	(0.6)
Carney Hospital	23	(1.1)	36	(1.3)
Charlton Memorial Hospital	13	(0.6)	16	(0.6)
Children's Hospital	28	(1.4)	32	(1.1)
Faulkner Hospital	17	(0.8)	23	(0.8)
Fenway Community Health Center	34	(1.7)	72	(2.6)
Framingham Union Hospital	9	(0.4)	14	(0.5)
Harvard Community Health Plan	59	(2.9)	98	(3.5)
Lahey Clinic	42	(2.1)	49	(1.8)
Lawrence General Hospital	7	(0.3)	12	(0.4)
Lemuel Shattuck Hospital	48	(2.4)	68	(2.4)
Massachusetts General Hospital	243	(12.1)	312	(11.2)
Mercy Hospital	5	(0.2)	12	(0.4)
Mt. Auburn Hospital	40	(2.0)	54	(1.9)
New England Deaconess Hospital	348	(17.4)	407	(14.6)
New England Medical Center	76	(3.8)	118	(4.2)
Newton-Wellesley Hospital	12	(0.6)	17	(0.6)
Quincy City Hospital	8	(0.4)	10	(0.4)
St. Elizabeth's Hospital	30	(1.5)	43	(1.5)
St. Luke's Hospital	24	(1.2)	46	(1.6)
Salem Hospital	10	(0.5)	11	(0.4)
University Hospital	46	(2.3)	50	(1.8)
Univ. of Mass Medical Center	46	(2.3)	70	(2.5)
V.A. Medical Center	44	(2.2)	61	(2.2)
Worcester City	6	(0.3)	10	(0.4)
Worcester Memorial	21	(1.0)	26	(0.9)
Other Boston Hospitals	24	(1.2)	29	(1.0)
Other Non-Boston Hospitals	161	(8.0)	273	(9.8)
TOTAL	2003	(100)	2794	(100)

For case reporting of AIDS patients meeting the CDC definition , please notify AIDS Epidemiologists at (617) 424-4377 (in Boston) or (617) 522-3700, ext. 482 (outside Boston).

AIDS SURVEILLANCE SUMMARY: STATE AND NATIONAL COMPARISONS

Total Cases as of 12/31/89	Massachusetts (2,794)* No.	(%)	United States (117,781) No.	(%)
Residence				
City of Boston	1,166	(42)		
Remainder SMSA**	654	(23)		
Remainder State	745	(27)		
Subtotal 2,565				
Out-of-State	229	(9)		
Transmission Categories (Adults)	2,745		115,786	
Homosexual/Bisexual Male	1,667	(61)	70,093	(61)
I.V. Drug User	510	(19)	24,212	(21)
Homosexual Male/I.V. Drug User	119	(4)	8,117	(7)
Hemophilia	41	(1)	1,062	(1)
Heterosexual Cases***	237	(9)	5,630	(5)
Transfusion Blood/Components	83	(3)	2,830	(2)
None of the Above	88	(3)	3,842	(3)
Transmission Categories (<13 yrs)	49		1,995	
Parent with AIDS/at risk for AIDS	41	(84)	1,614	(81)
Hemophilia	2	(4)	106	(5)
Transfusion, Blood/Components	6	(12)	208	(11)
None of the above	0	(0)	63	(3)
Sex				
Male	2,489	(89)	105,175	(89)
Female	305	(11)	10,611	(11)
Condition				
Alive	1,311	(47)	47,468	(40)
Dead	1,483	(53)	70,313	(60)
Race				
White	1,943	(70)	66,081	(56)
Black	553	(20)	32,248	(27)
Hispanic	279	(10)	18,284	(16)
Other/Unknown	19	(<1)	1,168	(1)
Age				
Under 13	49	(2)	1,995	(2)
13-19	15	(1)	461	(0)
20-29	567	(20)	24,056	(20)
30-39	1372	(49)	54,334	(46)
40-49	576	(21)	24,347	(21)
over 49	215	(8)	11,984	(10)

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*Includes 394 cases meeting the revised case definition.

**Refers to the Standard Metropolitan Statistical Area within Rte 495

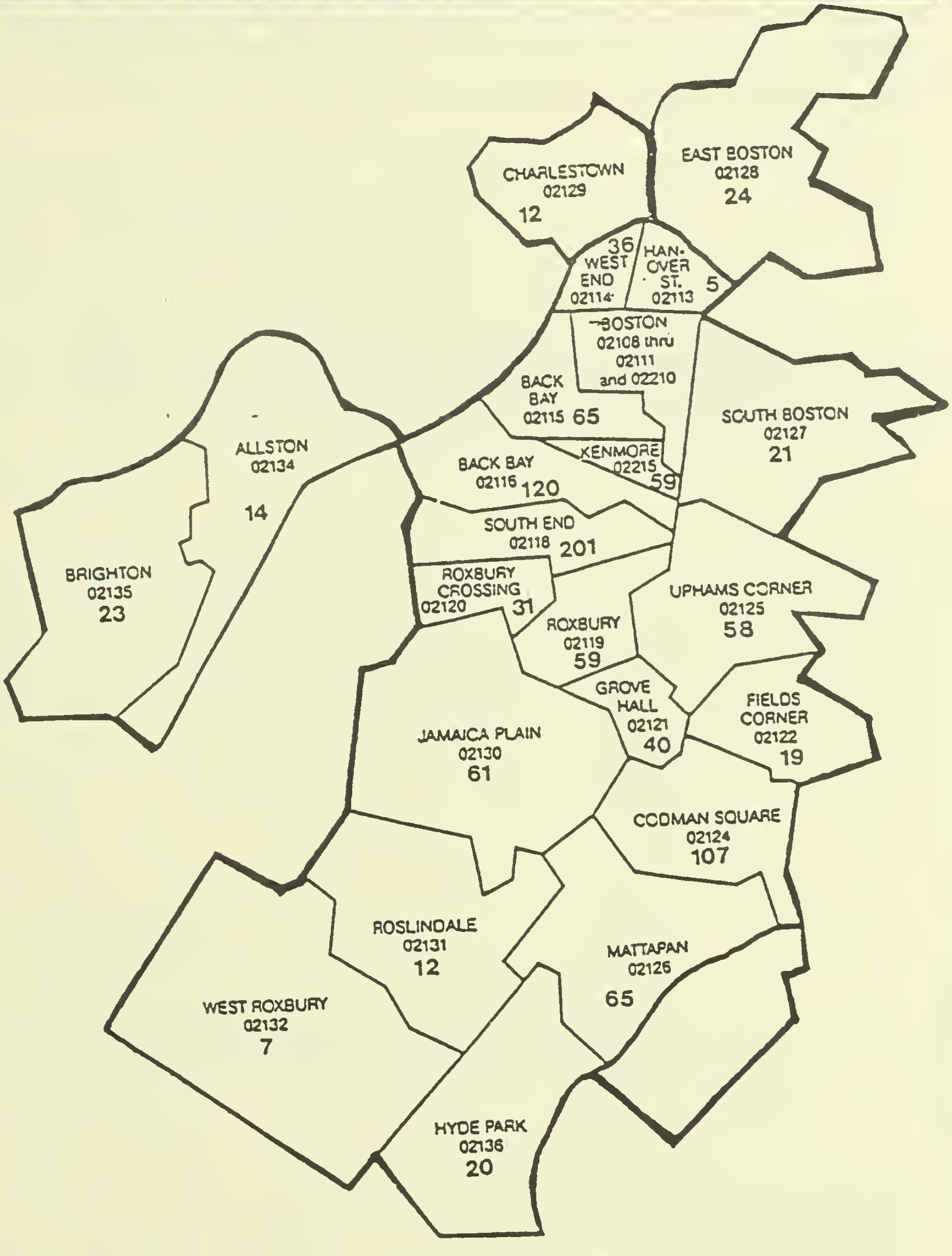
***Includes 95 persons who have had heterosexual contact with high risk individuals and 142 persons without other identified risks who were born in countries in which heterosexual transmission is believed to play a major role.

BOSTON AIDS CASES BY ZIP CODE OF RESIDENCE
THROUGH 12/31/89
N= 1,166

The 1,166 AIDS cases reported in the City of Boston cumulatively through 1989 rank Boston as twelfth among major U.S. metropolitan areas with populations greater than 500,000. Boston rates per 100,000 population for the individual years 1988 and 1989, respectively, have been 15.2 and 15.6. The small annual increment parallels trends in the averages among all major metropolitan areas, rates of 19.1 and 19.9 respectively. The high national average rates in recent years reflect a surge in cases elsewhere that has caused the ranking of Boston for recently reported cases (years 1988 and 1989) to drop to approximately 30th nationally.

Within the City of Boston (see map) cases are shown (in bold type) according to borough/zip code when five or more cases have been reported cumulatively through 1989. The table shows the attributed risk factor(s) among the 1,166 cases. The attributions to males with homosexual/bisexual contact (62%) and/or intravenous drug use (66%, inclusive) are similar to national figures of 61% and 68% respectively. The intravenous drug use (IVDU) attributions, in males and females, comprise 19%, as compared to 21% nationally. Heterosexual transmission is inferred in slightly more than 10%, and includes 27 that had contact with IVDU partners and 93 who were born in countries where heterosexual contact is prevalent.

For more information on AIDS cases in Boston, please contact Stephanie Oddleifson, AIDS Epidemiologist, at (617) 424-4377



Boston Resident AIDS Cases
through 12/31/89

Transmission Group	# Cases	%
Homo/Bisexual (male)	720	62%
Homo/Bisexual & IVDU (male)	42	4%
IVDU (male & female)	216	19%
Hemophiliac	3	-
Heterosexual Contact:		
with IVDU	27	2%
Born in Afr/Caribb.	93	8%
Other	8	-
Transfusion	8	-
Undetermined	29	2%
Pediatric (Age > 13)	20	2%
Total	1166	100%

CALENDAR

TUESDAY, MARCH 6, 1990, THIRD ANNUAL INFECTION CONTROL PRODUCT EXHIBIT OF NEW ENGLAND
9:30 A.M.-2:30 P.M. Sheraton Sturbridge Conference Center, Sturbridge, MA. This trade show, sponsored by the Association for Practitioners in Infection Control New England Chapter (APIC-NE) and Infection Control Consultants of America (ICCA), will be the largest exhibition of Infection Control Products (e.g. personal protective devices, medical/surgical supplies) and Services in the New England Region for the year. Registration fee is only $5.00. For more information please contact ICCA P.O. Box 5242, Turnpike Station, Shrewsbury, MA., Tel. (508) 443-0176.

WEDNESDAY, MARCH 7, 1990, ADOLESCENT AIDS NETWORKING BREAKFAST
9:00-10:00 A.M. Club Cafe, Columbus Avenue at East Berkley Street, Boston. The Adolescent AIDS Networking Breakfasts are held on the first Wednesday of each month. For more information please call Shoshana Rosenfeld at (617) 727-0368.

WEDNESDAY, MARCH 14, 1989, AIDS NETWORKING BREAKFAST
8:00-9:00 A.M. Club Cafe, Columbus Avenue at East Berkley Street, Boston. The AIDS Networking Breakfasts are held on the second Wednesday of each month. For more information please call Ann Sanders at 725-3485 or Rhoda Johnson at (617) 424-4559.

ANNOUNCEMENT
HIV DRUG REIMBURSEMENT PLAN UPDATE
The Massachusetts Department of Public Health has announced some changes in the HIV Drug Reimbursement Plan (HDRP), which supplies HIV related drugs to individuals. The HDRP will now be coordinated by the Community Research Initiative of New England. The new address is 338 Newbury Street, Boston, MA 02115 For further information, please call (617) 262-0869 or 1-800-228-2714 outside the Boston area. English, Spanish and Portuguese language services are available at both phone numbers. Individuals in financial need are encouraged to apply for assistance in obtaining AZT, aerosolized pentamidine, or alpha interferon. All inquiries will be kept confidential.

A Publication of the AIDS Surveillance Program

George R. Seage III **Jeanne Day** **Stephanie Oddleifson**
Laurie Kunches **Beverly Heinze-Lacey** **Laurie Makarewicz**

Boston Department of Health and Hospitals
House Officers Building, Room 321
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AIDS NEWSLETTER

a monthly publication from the
Massachusetts Department of Public Health/Boston Department of Health and Hospitals

Vol. 6 **February, 1990** **No. 2**

UPDATE

During January, a record high eighty-nine new AIDS cases were reported to the Massachusetts AIDS Surveillance Program. A total of 9 pediatric cases (under 13 years of age) were reported in January, which brings the cumulative number of children with AIDS reported in Massachusetts up to 58 cases. Of the 9 pediatric cases, 3 were diagnosed in 1988, 5 in 1989, and 1 in 1990. This high monthly total of pediatric cases is due partly to the activities of the Surveillance of HIV Infection in Children (SHIVIC) Project (See May 1989 and October 1989 Newsletters). In December 1989, record reviews were conducted in Massachusetts hospitals which report greater than 90% of the pediatric AIDS cases. This review resulted in some previously unreported and some new AIDS cases in children being reported during January 1990.

MASSACHUSETTS RESIDENT CASES AND CUMULATIVE INCIDENCE RATES BY COUNTY

COUNTY	NUMBER	%MA CASES	CASES PER MILLION
Berkshire	21	0.8	144.7
Bristol	112	4.2	236.0
Cape and Islands	129	4.8	811.2
Essex	158	6.0	249.4
Franklin	12	0.5	186.6
Hampden	106	4.0	239.3
Hampshire	18	0.7	129.7
Middlesex	430	16.2	314.5
Norfolk	158	6.0	260.5
Plymouth	109	4.1	268.8
Suffolk	1265	47.8	1945.7
Worcester	130	4.9	201.1
TOTAL	2648	100	461.6

For case reporting of AIDS patients meeting the CDC definition, please notify AIDS Epidemiologists at (617) 424-4377 (in Boston) or (617) 522-3700, ext. 482 (outside Boston).

AIDS SURVEILLANCE SUMMARY: STATE AND NATIONAL COMPARISONS

Total Cases as of 1/31/90	Massachusetts (2,881)* No.	(%)	United States (121,645)** No.	(%)
Residence				
City of Boston	1,208	(42)		
Remainder SMSA	671	(23)		
Remainder State	769	(27)		
Subtotal 2,648				
Out-of-State	233	(8)		
Transmission Categories (Adults)	2,823		119,590	
Homosexual/Bisexual Male	1,712	(61)	72,153	(60)
I.V. Drug User	526	(19)	25,200	(21)
Homosexual Male/I.V. Drug User	120	(4)	8,326	(7)
Hemophilia	41	(1)	1,099	(<1)
Heterosexual Cases***	250	(9)	5,853	(5)
Transfusion Blood/Components	84	(3)	2,923	(2)
None of the Above	90	(3)	4,036	(3)
Transmission Categories (<13 yrs)	58		2,055	
Parent with AIDS/at risk for AIDS	50	(86)	1,675	(82)
Hemophilia	2	(3)	108	(5)
Transfusion, Blood/Components	6	(10)	217	(11)
None of the above	0	(0)	55	(3)
Sex				
Male	2,564	(89)	109,656	(90)
Female	317	(11)	11,989	(10)
Condition				
Alive	1,596	(46)	49,067	(41)
Dead	1,551	(54)	72,578	(60)
Race				
White	1,996	(69)	68,034	(56)
Black	578	(20)	33,419	(27)
Hispanic	288	(10)	18,890	(16)
Other/Unknown	19	(<1)	1,212	(<1)
Age				
Under 13	58	(2)	2,055	(2)
13-19	15	(1)	479	(<1)
20-29	583	(20)	24,801	(20)
30-39	1,414	(49)	56,101	(46)
40-49	591	(21)	25,834	(21)
over 49	220	(8)	12,375	(10)

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*Includes 436 cases meeting the revised case definition.

**Total Cases as of 1/31/90.

***Includes 101 persons who have had heterosexual contact with high risk individuals and 149 persons without other identified risks who were born in countries in which heterosexual transmission is believed to play a major role.

AIDS CASE REPORTS AND RATES IN MASSACHUSETTS COMMUNITITES

In order to help protect the confidentiality of individual AIDS patients in communities of low prevalence, and to prevent over-interpretation of meaningless variations in small numbers, our Newsletter has presented monthly trends only for geographic areas that have had more than 5 case reports. We have shown that the proportion of patients with an out-of-state principal residence has dropped steadily, to 9%, as expert care has become available across the country. Among the 14 counties in Massachusetts, all but Dukes County (Martha's Vineyard) have reported more than 5 cases. Among the 351 cities and towns in Massachusetts, 55 (16%) have reported more than 5 cases as shown in the table below. Another 179 communities have reported at least one case, bringing to 232 the total number of Massachusetts communities affected, i.e. approximately 2/3 (67%).

COMMUNITIES WITH GREATER THAN 5 AIDS CASES

	TOTAL NUMBER	CUMULATIVE RATE PER 100,000 POPULATION
Arlington	15	31
Attleboro	7	20
Beverly	10	27
Billerica	7	19
Boston	1,207	214
Braintree	7	19
Bridgewater**	7	41
Brockton	48	50
Brookline	36	65
Cambridge	90	94
Chelsea	21	83
Chicopee	13	24
Concord**	7	43
Everett	12	32
Fall River	14	15
Fitchburg	8	20
Framingham**	22	34
Gloucester	9	32
Haverhill	8	17
Holyoke	9	20
Lawrence	27	43
Leominster	7	20
Lexington	7	24
Lowell	27	29
Lynn	25	32
Malden	24	45
Medford	16	28
Methuen	8	22
Milton	9	34
Nantucket*	7	--
Natick	8	27
New Bedford	61	62
Newton	15	18
Northampton	8	27
Peabody	12	26
Pittsfield	7	13
Plymouth	12	33
Provincetown*	74	--
Quincy	26	31
Reading	8	35
Revere	25	59
Salem	10	26
Saugus	9	36
Somerville	62	80
Springfield	69	45
Stoughton	9	34
Taunton	7	16
Wakefield	6	24
Waltham	8	14
Watertown	12	35
Weymouth	16	29
Wilmington	6	34
Winchester	6	29
Winthrop**	8	41
Worcester	63	39

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* Rate not calculated for population estimates that have wide seasonal variations.

** AIDS cases in correctional facilities were excluded from this analysis.

CALENDAR

WEDNESDAY, APRIL 11, 1990, AIDS NETWORKING BREAKFAST

8:00-9:00 AM. The April Breakfast will be held at the Boston Living Center, 140 Clarendon Street (YWCA) on the 7th floor. Peg Lorenz, AIDS Educator at Boston City Hospital, will present "Taking Care of the Caregiver." The AIDS Networking Breakfasts are held on the second Wednesday of each month. For more information please call Ann Sanders at 725-3485 or Rhoda Johnson at (617) 424-4559.

MONDAY, APRIL 30, 1990, STATEWIDE HIV EDUCATORS MEETING

HIV educators meetings are held on the last Monday of each month from 10:00 AM to 3:00 PM. For more information on location of the meetings please call Ruth Karmelin-Bice at (508) 947-1231, Extension 586. If you want to be added to the mailing list, please call Mary McConnell at (617) 727-0368.

WEDNESDAY, MAY 2, 1990, ADOLESCENT AIDS NETWORKING BREAKFAST

9:00-10:00 AM. Club Cafe, Columbus Avenue at East Berkley Street, Boston. The Adolescent AIDS Networking Breakfasts are held on the first Wednesday of each month. For more information please call Shoshana Rosenfeld at (617) 727-0368.

WEDNESDAY AND THURSDAY, MAY 16 -17, 1990, STATEWIDE CONFERENCE ON "HIV/DISABILITY: BUILDING BRIDGES IN OUR COMMUNITIES"

The Massachusetts Developmental Disabilities Council and the Massachusetts Department of Public Health are sponsoring this conference at the Worcester Marriot. The purpose of the conference is for people with HIV infection and their caretakers to meet people with other disabilities and their providers. The conference will include workshops on legal rights, health care, employment, providers' liability, and other issues. There is no registration fee for people with HIV/AIDS or other disabilities. Some scholarships are available based on financial need. For more information or to receive a brochure, please call Jo Bower at (617) 727-6374.

ANNOUNCEMENT ON HIV DRUG REIMBURSEMENT PLAN

The HIV Drug Reimbursement Plan (HDRP), which supplies HIV related drugs to individuals, will now be coordinated by the Community Research Initiative of New England. The new address is 338 Newbury Street, Boston, MA 02115. For further information, please call (617) 262-0889 or 1-800-228-2714 outside the Boston area. English, Spanish and Portuguese language services are available at both phone numbers. Individuals in financial need are encouraged to apply for assistance in obtaining AZT, aerosolized pentamidine, or alpha interferon. All inquiries will be kept confidential.

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GOVERNMENT DOCUMENTS COLLECTION

AIDS NEWSLETTER

a monthly publication from the
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Vol. 6 March, 1990 No. 3

UPDATE

During January, a total of seventy-seven new AIDS cases were reported to the Massachusetts AIDS Surveillance Program.

CUMULATIVE AIDS CASES BY INSTITUTION AND YEAR OF REPORT

Institution	as of 03/01/89		as of 03/01/90	
	No.	(%)	No.	(%)
Atlanticare Medical Center	9	(0.4)	10	(0.3)
Baystate Medical Center	60	(2.8)	99	(3.3)
Berkshire Medical Center	12	(0.6)	17	(0.6)
Beth Israel Hospital	175	(8.2)	221	(7.5)
Boston City Hospital	194	(9.1)	286	(9.7)
Brigham & Women's Hospital	152	(7.1)	198	(6.7)
Cambridge Hospital	14	(0.7)	21	(0.7)
Cape Cod Hospital	13	(0.6)	18	(0.6)
Carney Hospital	24	(1.1)	37	(1.3)
Charlton Memorial Hospital	14	(0.7)	18	(0.6)
Children's Hospital	28	(1.3)	36	(1.2)
Faulkner Hospital	17	(0.8)	23	(0.8)
Fenway Community Health Center	38	(1.8)	98	(3.3)
Framingham Union Hospital	12	(0.6)	14	(0.5)
Harvard Community Health Plan	67	(3.1)	99	(3.3)
Lahey Clinic	43	(2.0)	49	(1.7)
Lawrence General Hospital	7	(0.3)	15	(0.5)
Lemuel Shattuck Hospital	51	(2.4)	71	(2.4)
Massachusetts General Hospital	257	(12.0)	321	(10.9)
Mercy Hospital	5	(0.2)	15	(0.5)
Mt. Auburn Hospital	41	(1.9)	57	(1.9)
New England Deaconess Hospital	356	(16.7)	415	(14.0)
New England Medical Center	78	(3.7)	129	(4.4)
Newton-Wellesley Hospital	15	(0.7)	17	(0.6)
Quincy City Hospital	8	(0.4)	10	(0.3)
St. Elizabeth's Hospital	32	(1.5)	46	(1.6)
St. Luke's Hospital	29	(1.4)	51	(1.7)
Salem Hospital	10	(0.5)	11	(0.4)
University Hospital	47	(2.2)	51	(1.7)
Univ. of Mass Medical Center	52	(2.4)	70	(2.4)
V.A. Medical Center	46	(2.2)	63	(2.1)
Worcester City	6	(0.3)	10	(0.3)
Worcester Memorial	22	(1.0)	26	(0.9)
Other Boston Hospitals	26	(1.2)	31	(1.0)
Other Non-Boston Hospitals	173	(8.1)	303	(10.3)
TOTAL	2133	(100)	2956	(100)

For case reporting of AIDS patients meeting the CDC definition , please notify AIDS Epidemiologists at (617) 424-4377 (in Boston) or (617) 522-3700, ext. 482 (outside Boston).

AIDS SURVEILLANCE SUMMARY: STATE AND NATIONAL COMPARISONS

Total Cases as of 2/28/90	Massachusetts (2,956)*		United States (124,984)**	
	No.	(%)	No.	(%)
Residence				
City of Boston	1,230	(42)		
Remainder SMSA	686	(23)		
Remainder State	806	(27)		
Subtotal 2,722				
Out-of-State	234	(8)		
Transmission Categories (Adults)	2,894		122,868	
Homosexual/Bisexual Male	1,749	(60)	73,990	(60)
I.V. Drug User	554	(19)	26,092	(21)
Homosexual Male/I.V. Drug User	120	(4)	8,530	(7)
Hemophilia	42	(1)	1,114	(<1)
Heterosexual Cases***	254	(9)	6,027	(5)
Transfusion Blood/Components	85	(3)	2,984	(2)
None of the Above	90	(3)	4,131	(3)
Transmission Categories (<13 yrs)	62		2,116	
Parent with AIDS/at risk for AIDS	54	(87)	1,734	(82)
Hemophilia	2	(3)	108	(5)
Transfusion, Blood/Components	6	(10)	219	(10)
None of the above	0	(0)	55	(3)
Sex				
Male	2,628	(89)	112,614	(90)
Female	328	(11)	12,370	(10)
Condition				
Alive	1,348	(46)	48,954	(39)
Dead	1,608	(54)	76,030	(61)
Race				
White	2,039	(69)	69,743	(56)
Black	599	(20)	34,431	(28)
Hispanic	298	(10)	19,565	(16)
Other/Unknown	20	(<1)	1,245	(<1)
Age				
Under 13	62	(2)	2,116	(2)
13-19	15	(1)	486	(<1)
20-29	597	(20)	25,428	(20)
30-39	1,448	(49)	57,675	(46)
40-49	610	(21)	26,586	(21)
over 49	224	(8)	12,693	(10)

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*Includes 457 cases meeting the revised case definition.

**Total Cases as of 2/28/90.

***Includes 104 persons who have had heterosexual contact with high risk individuals and 150 persons without other identified risks who were born in countries in which heterosexual transmission is believed to play a major role.

UNRECOGNIZED HIV INFECTION IN STD CLINIC PATIENTS

Voluntary HIV counseling and testing (C & T) has been available through Massachusetts Sexually Transmitted Disease (STD) clinics since June 1987. The objectives of HIV C & T are to provide individuals with knowledge of their HIV status and to encourage changes in behavior that will reduce the risk of infecting others or of becomming infected with HIV. Counseling and appropriate referral can also facilitate early medical management of HIV-infected persons.

To evaluate the success of the voluntary HIV C & T Program in reaching those individuals most at risk for HIV infection, we undertook an unlinked anonymous HIV serosurvey of patients attending Boston area STD clinics. The unlinked serosurvey allows us to compare the characteristics of patients accepting voluntary HIV testing with the general STD clinic population.

The three STD clinics, included in this study represent suburban, metropolitan, and inner city sites. This article reports on data collected in these clinics from September 1, 1988 through December 31, 1989. During this period, 5,318 unlinked specimens (leftover sera from blood drawn for syphilis serology testing and from which all identifiers have been removed) were tested for antibody to HIV-1.

All patients seen at these STD clinics receive general AIDS education and information on availability of HIV-1 antibody testing. During the study period, 1,165 patients requested HIV C & T. Sera from these 1,165 patients were also included in the 5,318 specimens tested in the unlinked serosurvey.

RESULTS

Specimens from the unlinked serosurvey showed an overall seropositivity rate of 3.6% versus 5.2% seropositivity among those patients requesting voluntary HIV C & T. Selective avoidance of voluntary testing by high-risk individuals, reported by other investigators, was not observed in our study.

Of the 194 HIV-infected patients attending the three STD clinics during the study period, 61 (31%) requested HIV C & T. Forty-six percent (17/37) of white HIV-infected patients versus 25% (28/114) of black and 36% (13/36) of Hispanic HIV-infected patients requested HIV C & T.

When analyzed by self-reported risk, we found that 44% (39/89) of the HIV-infected patients traditionally recognized as "high risk" (gay and/or IVDU) requested voluntary HIV C & T. This compares to the 22% (22/105) of HIV-infected patients reporting other* or no risk factors who requested voluntary HIV C & T.

CONCLUSION

STD clinics provide an opportunity to reach individuals who are at risk for HIV infection, since people at risk for an STD are also at risk for HIV infection. Our

RESULTS OF UNLINKED AND VOLUNTARY (LINKED) HIV-1 TESTING
IN STD CLINIC PATIENTS
(9/1/88 - 12/31/89)
ACCORDING TO SEX, RACE AND SELF-REPORTED RISK CATEGORY

	UNLINKED TEST GROUP		VOLUNTARY TEST GROUP		
	No. Tested	HIV Pos No. (%)	No. Tested	HIV Pos No. (%)	Percent Of HIV+ Pts. Who Request C & T
TOTAL	5,318	194 (3.6%)	1,165	61 (5.2%)	31% (61/194)
SEX					
Male	3,962	167 (4.2%)	779	50 (6.4%)	30% (50/167)
Female	1,356	27 (2.0%)	359	9 (2.5%)	33% (9/27)
Unknown	0	0	27	2 (7.4%)	-
RACE					
White	1,611	37 (2.3%)	594	17 (2.9%)	46% (17/37)
Black	2,857	114 (4.0%)	380	28 (7.4%)	25% (28/114)
Hispanic	533	36 (6.8%)	137	13 (9.5%)	36% (13/36)
Other/Unknown	317	7 (2.2%)	71	3 (4.2%)	43% (3/7)
RISK CATEGORY					
Gay/bisexual	169	46 (27.2%)	90	14 (15.6%)	30% (14/46)
IVDU	192	43 (22.4%)	108	25 (23.2%)	58% (25/43)
Other *	4,957	105 (2.1%)	967	22 (22.8%)	22% (22/105)

data show that a large proportion (69%) of HIV infected patients seen at the STD clinics studied did not request voluntary HIV counseling and testing. While some of these patients may already know their HIV status, we assume that most do not. The majority of HIV infected patients who requested HIV C & T reported "high risk" behaviors (gay and/or IVDU). The unlinked serosurvey data, however, show that the majority of HIV infected patients seen in these STD clinics did not report these behaviors.

There are several reasons why voluntary HIV C & T programs in STD clinics may not be reaching those who could benefit from these services. Concerns regarding confidentiality and the potential of discrimination may deter patients from requesting HIV C & T. Knowledge of one's HIV status may not be a priority, particularly for those who do not see themselves at risk. Limited time and resources make it difficult for STD clinic staff to target HIV C & T efforts to any but those they considered to be at high risk. It is important to note that most HIV-infected people do not meet generally accepted "high risk" criteria by self-report. In order to improve the success of STD clinic voluntary HIV C & T programs in reaching people at risk for HIV infection, it would be necessary to encourage HIV C & T for all STD clinic patients. Our data indicate that black and Hispanic HIV-infected patients were less likely than white HIV-infected patients to request HIV C & T. The sensitive nature of HIV C & T requires that linguistically and culturally appropriate services be available in these settings.

An increased commitment of resources will be needed if more STD clinic patients are to benefit from voluntary HIV counseling and testing.

* High risk partner, blood recipient, imigrant from Africa or Caribbean, exchanged sex for money/drugs, multiple sex partners, premarital/prenatal concerns, lesbian sexual contact, health worker, other or no reported risk.

CALENDAR

WEDNESDAY, MAY 2, 1990, ADOLESCENT AIDS NETWORKING BREAKFAST
9:00-10:00 AM Club Cafe, Columbus Avenue at East Berkley Street, Boston. The Adolescent AIDS Networking Breakfasts are held on the first Wednesday of each month. For more information please call Shoshana Rosenfeld at (617) 727-0368.

WEDNESDAY, MAY 9, 1990, AIDS NETWORKING BREAKFAST
8:00-9:00 AM. The May Breakfast will be held at the Boston Living Center, 140 Clarendon Street (YWCA) on the 7th floor. The AIDS Networking Breakfasts are held on the second Wednesday of each month. For more information please call Ann Sanders at 725-3485 or Rhoda Johnson at (617) 424-4559.

A Publication of the AIDS Surveillance Program

George R. Seage III
Jeanne Day
Stephanie Oddleifson
Laurie Kunches
Beverly Heinze-Lacey
Laurie Makarewicz

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155. HS30.21:6/4

GOVERNMENT DOCUMENTS COLLECTION

AIDS NEWSLETTER

a monthly publication from the
Massachusetts Department of Public Health/Boston Department of Health and Hospitals

Vol. 6 April, 1990 No. 4

UPDATE

During March, a total of fifty-four new AIDS cases were reported to the Massachusetts AIDS Surveillance Program. There is an increasing tendency on the part of the federal government to fund cities and states based on the numbers and rates of AIDS cases. The Kennedy-Hatch Comprehensive AIDS Resource Emergency Act recently introduced in the Senate is awaiting approval by the Legislature. This bill will provide direct financial support to hospitals, clinics, nursing homes, and community health centers treating HIV/AIDS patients in 13 cities with 2,000 or more AIDS cases, including Boston. Because both low and high prevalence areas will continue to receive funding, in part, on the basis of AIDS cases, it is imperative for hospitals and providers to report all AIDS cases to the state health department in a timely fashion. If there are any questions about AIDS case reporting, please call 617-534-5916 (in Boston) or 617-522-3700, Ext. 478 or Ext. 482 (outside Boston).

MASSACHUSETTS RESIDENT CASES

AND CUMULATIVE INCIDENCE RATES BY COUNTY

COUNTY	NUMBER	%MA CASES	CASES PER MILLION
Berkshire	21	0.8	144.7
Bristol	118	4.3	248.6
Cape and Islands	134	4.8	854.2
Essex	166	6.0	262.0
Franklin	13	0.5	202.1
Hampden	130	4.7	293.4
Hampshire	20	0.7	144.1
Middlesex	444	16.0	324.8
Norfolk	164	5.9	270.4
Plymouth	114	4.1	281.2
Suffolk	1318	47.5	2027.2
Worcester	131	4.7	202.7
TOTAL	2774	100	483.5

For case reporting of AIDS patients meeting the CDC definition , please notify AIDS Epidemiologists at (617) 424-4377 (in Boston) or (617) 522-3700, ext. 482 (outside Boston).

AIDS SURVEILLANCE SUMMARY: STATE AND NATIONAL COMPARISONS

Total Cases as of 4/30/90	Massachusetts (3,010)*		United States (128,319)**	
	No.	(%)	No.	(%)
Residence				
City of Boston	1,255	(42)		
Remainder SMSA	699	(23)		
Remainder State	820	(27)		
Subtotal 2774				
Out-of-State	236	(8)		
Transmission Categories (Adults)	2,715		126,127	
Homosexual/Bisexual Male	1,622	(60)	75,853	(60)
I.V. Drug User	546	(20)	26,883	(21)
Homosexual Male/I.V. Drug User	105	(4)	8,711	(7)
Hemophilia	37	(1)	1,141	(1)
Heterosexual Cases***	246	(9)	6,231	(5)
Transfusion Blood/Components	73	(3)	3,040	(2)
None of the Above	86	(3)	4,268	(3)
Transmission Categories (<13 yrs)	59		2,192	
Parent with AIDS/at risk for AIDS	53	(90)	1,801	(82)
Hemophilia	2	(3)	113	(5)
Transfusion, Blood/Components	4	(7)	223	(10)
None of the above	0	(0)	55	(3)
Sex				
Male	2,456	(89)	115,575	(90)
Female	318	(11)	12,744	(10)
Condition				
Alive	1,241	(45)	49,979	(39)
Dead	1,533	(55)	78,340	(61)
Race				
White	1,878	(68)	71,517	(56)
Black	589	(21)	35,472	(28)
Hispanic	290	(10)	20,062	(15)
Other/Unknown	17	(<1)	953	(1)
Age				
Under 13	59	(2)	2,192	(2)
13-19	15	(1)	500	(0)
20-29	561	(21)	26,035	(20)
30-39	1,363	(49)	59,266	(46)
40-49	573	(21)	27,331	(21)
over 49	203	(7)	12,995	(10)

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*Includes 449 cases meeting the revised case definition.

**Total Cases as of 3/31/90.

***Includes 107 persons who have had heterosexual contact with high risk individuals and 151 persons without other identified risks who were born in countries in which heterosexual transmission is believed to play a major role.

HIV COUNSELING AND TESTING SERVICES IN MASSACHUSETTS

HIV testing is requested in a number of different health care settings: private doctor's offices, community health centers (CHCs), Anonymous Test Sites (ATS), sexually transmitted disease (STD) clinics, correctional facilities, and substance abuse treatment centers. The Department of Public Health only has information on the demand for testing at sites that are funded to provide counseling and testing services by the state. An analysis of the demand at the twenty state-funded Anonymous Test Sites (ATS) and thirteen state-funded confidential (STD) test sites was conducted in 1989.

The total number of individuals requesting pre-test counseling sessions at ATS in 1989 (7.104) was 15% greater than the total number in 1988 (6,070). At the same time, the total number of individuals tested in 1989 (6,881) was 16% higher than the number tested in 1988 (5,790).

In the last six months of 1989, requests for anonymous counseling and testing increased during two months, August and November. The increase in August may have been linked to the announcement that New York was going to encourage HIV antibody testing. The increase in November may have been related to the extra publicity given to ATS services during AIDS Awareness Month.

Throughout 1989, STD clinics offered a constant level of confidential counseling and testing services because there was little month-to-month variation in STD clinic hours and number of nurses. Nevertheless, the total number of individuals tested at STD sites increased by 18% in 1989 (2,972) from 1988 (2,448). The number of post-test sessions also increased from 1988 (1.567) by 17% in 1989 (1,881).

The increase in overall numbers of high risk clients is probably due to increased awareness of the benefits of early intervention for those who test positive. The steady rise in the number of low risk individuals requesting testing services may reflect a heightened awareness about HIV infection among the heterosexual population. Thus the net effect is a decrease in the proportion of high risk* clients even as their absolute numbers increase (see Table).

Four factors are needed in order for the Department of Public Health to continue to respond to the demand for HIV antibody testing in 1990. These factors include 1) agencies willing to host the service; 2) trained counselors: 3) bilingual/bicultural counseling services; and 4) trained laboratory staff who can produce test results in an accurate and timely fashion.

Finding interested agencies is not a problem. A number of agencies throughout the state, located in areas where there are people who have risk behaviors associated with HIV infection, are interested in providing HIV counseling and testing services.

There is a shortage of trained counselors and trained health care staff. The Department is currently providing a monthly HIV Counseling Techniques course, developed by the Centers for Disease Control, to health care providers. Technical supervision, inservice training, and follow-up are also provided by the Department of Public Health HIV Counselors.

The Department provides continuing education which addresses HIV/AIDS cultural issues for different racial, ethnic and linguistic populations. Bilingual/bicultural healthcare staff requesting counseling training are also given priority during course registration.

ANONYMOUS TEST SITES (ATS) HIV-1 TESTING

	No. Tested	No. High Risk	Percent High Risk
1985	616	494	80%
1986	1,389	1,006	72%
1987	3,454	2,192	63%
1988	5,790	2,726	48%
1989	6,881	3,180	46%

* High Risk: gay/bisexual males, intravenous drug users, blood transfusion recipients, immigrants from Africa/Caribbean, persons with hemophilia

CALENDAR

WEDNESDAY, June 6, 1990, ADOLESCENT AIDS NETWORKING BREAKFAST

9:00-10:00 AM. Club Cafe, Columbus Avenue at East Berkley Street, Boston. The Adolescent AIDS Networking Breakfasts are held on the first Wednesday of each month. For more information please cal Shoshana Rosenfeld at (617) 727-0368.

AIDS NETWORKING BREAKFAST

There will be no meetings during the months of June, July, and August. The AIDS Networking Breakfasts will resume in September. For more information please call Ann Sanders at 725-3485 or Rhoda Johnson at (617) 424-4559.

WEDNESDAY, JUNE 27, 1990, SEMINAR: THE SEROLOGIC DIAGNOSIS OF HIV-1 INFECTION

8:00 AM-5:30 PM. At the State Laboratory Institute, Jamaica Plain, MA. For more information, call Betty Brosman or Marcia Stowell at the National Laboratory Training Network, (617) 522-3700, Ext. 140 or Ext. 153.

WEDNESDAY AND THURSDAY, JUNE 27 & 28, 1990, 1-1/2 DAY HIV-1 SEMINAR/ DEMONSTRATION

9:00 AM-4:30 PM. This seminar will cover laboratory diagnostic tests at the Rhode Island Department of Public Health Laboratories, Providence, RI. For more information, call Beverly McKenna at (401) 274-1011 or the National Laboratory Training Network (see above).

THURSDAY AND FRIDAY, JUNE 28 & 29, 1990, WORKSHOP: THE SEROLOGIC DIAGNOSIS OF HIV-1 INFECTION.

8:00 AM-4:00 PM. At the State Laboratory Institute, Jamaica Plain, MA. Hands-on workshop covering laboratory diagnostic tests. For more information, call the National Laboratory Training Network (see above).

MONDAY-WEDNESDAY, AUGUST 6-8, 1990, THE FOURTH INTERNATIONAL CONFERENCE ON AIDS

This interdisciplinary educational conference focuses on 'Challenges and Choices for the 90s' in approaches to prevention and control of AIDS. It will take place at the El Juan Hotel, San Juan, Puerto Rico. For more information, contact Donna L. Richter, Ed.D., University of South Carolina, School of Public Health, Colombia, SC, 29208. Telephone (803) 777-4845.

A Publication of the AIDS Surveillance Program

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AIDS NEWSLETTER

a monthly publication from the
Massachusetts Department of Public Health/Boston Department of Health and Hospitals

Vol. 6 May, 1990 No. 5

GOVERNMENT DOCUMENTS COLLECTION
SEP 12 1990

UPDATE

During April, a total of eighty-eight AIDS cases were reported to the Massachusetts AIDS Surveillance Program.

CUMULATIVE AIDS CASES BY INSTITUTION AND YEAR OF REPORT

Institution	as of 05/01/89		as of 05/01/90	
	No.	(%)	No.	(%)
Atlanticare Medical Center	10	(0.4)	11	(0.4)
Baystate Medical Center	68	(3.0)	101	(3.3)
Berkshire Medical Center	14	(0.6)	17	(0.5)
Beth Israel Hospital	189	(8.3)	230	(7.4)
Boston City Hospital	207	(9.1)	296	(9.6)
Brigham & Women's Hospital	159	(7.0)	203	(6.6)
Cambridge Hospital	16	(0.7)	22	(0.7)
Cape Cod Hospital	14	(0.6)	20	(0.6)
Carney Hospital	32	(1.4)	37	(1.2)
Charlton Memorial Hospital	15	(0.7)	19	(0.6)
Children's Hospital	29	(1.3)	40	(1.3)
Faulkner Hospital	20	(0.9)	25	(0.8)
Fenway Community Health Center	40	(1.8)	124	(4.0)
Framingham Union Hospital	12	(0.5)	14	(0.5)
Harvard Community Health Plan	67	(3.0)	111	(3.6)
Lahey Clinic	44	(1.9)	49	(1.6)
Lawrence General Hospital	10	(0.4)	15	(0.5)
Lemuel Shattuck Hospital	54	(2.4)	77	(2.5)
Massachusetts General Hospital	272	(12.0)	322	(10.4)
Mercy Hospital	7	(0.3)	20	(0.6)
Mt. Auburn Hospital	42	(1.9)	62	(2.0)
New England Deaconess Hospital	375	(16.5)	425	(13.7)
New England Medical Center	82	(3.6)	134	(4.3)
Newton-Wellesley Hospital	15	(0.7)	17	(0.5)
Quincy City Hospital	9	(0.4)	11	(0.4)
St. Elizabeth's Hospital	33	(1.5)	49	(1.6)
St. Luke's Hospital	34	(1.5)	51	(1.6)
Salem Hospital	10	(0.4)	11	(0.4)
University Hospital	48	(2.1)	53	(1.7)
Univ. of Mass Medical Center	54	(2.4)	75	(2.4)
V.A. Medical Center	47	(2.1)	64	(2.1)
Worcester City	9	(0.4)	11	(0.4)
Worcester Memorial	22	(1.0)	26	(0.8)
Other Boston Hospitals	28	(1.2)	33	(1.1)
Other Non-Boston Hospitals	182	(8.0)	323	(10.4)
TOTAL	2269	(100)	3098	(100)

For case reporting of AIDS patients meeting the CDC definition , please notify AIDS Epidemiologists at (617) 424-4377 (in Boston) or (617) 522-3700, ext. 482 (outside Boston).

AIDS SURVEILLANCE SUMMARY: STATE AND NATIONAL COMPARISONS

Total Cases as of 5/01/90	Massachusetts (3,098)* No.	 (%)	United States (132,510)** No.	 (%)
Residence				
City of Boston	1,282	(42)		
Remainder SMSA	725	(23)		
Remainder State	851	(27)		
Subtotal 2,858				
Out-of-State	240	(8)		
Transmission Categories (Adults)	3,030		130,252	
Homosexual/Bisexual Male	1,835	(61)	78,212	(59)
I.V. Drug User	577	(19)	27,842	(21)
Homosexual Male/I.V. Drug User	125	(4)	8,948	(7)
Hemophilia	45	(1)	1,171	(<1)
Heterosexual Cases***	265	(9)	6,532	(5)
Transfusion Blood/Components	86	(3)	3,119	(2)
None of the Above	97	(3)	4,421	(3)
Transmission Categories (<13 yrs)	68		2,258	
Parent with AIDS/at risk for AIDS	60	(88)	1,863	(83)
Hemophilia	2	(3)	114	(5)
Transfusion, Blood/Components	6	(9)	226	(10)
None of the above	0	(0)	55	(2)
Sex				
Male	2,759	(89)	118,016	(90)
Female	339	(11)	12,236	(10)
Condition				
Alive	1,401	(45)	51,711	(39)
Dead	1,697	(55)	80,799	(61)
Race				
White	2,146	(69)	73,746	(56)
Black	615	(20)	36,682	(28)
Hispanic	317	(10)	20,765	(16)
Other/Unknown	20	(<1)	1,317	(<1)
Age				
Under 13	68	(2)	2,258	(2)
13-19	15	(1)	513	(<1)
20-29	630	(20)	26,870	(20)
30-39	1,511	(49)	61,170	(46)
40-49	644	(21)	28,264	(21)
over 49	230	(7)	13,435	(10)

*Includes 493 cases meeting the revised case definition.

**Total Cases as of 4/30/90.

***Includes 110 persons who have had heterosexual contact with high risk individuals and 155 persons without other identified risks who were born in countries in which heterosexual transmission is believed to play a major role.

POLYMERASE CHAIN REACTION (PCR) AND ITS APPLICATIONS TO CLINICAL DIAGNOSIS OF HIV

The Polymerase chain reaction (PCR) is a molecular biology technique developed in the mid 1980's by the Cetus Corporation. PCR has many potential clinical applications that include the detection of genetic mutations or infectious agents in clinical specimens. However. these applications are currently being evaluated and are not presently available for clinical diagnosis of disease.

HIV, which may be present at very low concentrations in the blood (one virus per 10,000 mononuclear cells), is an infectious agent whose detection might be facilitated by PCR. Although still in the research and development stage, early indications are that PCR is more sensitive than antigen assays, and less time consuming and less biohazardous than HIV culture. If HIV infection can be compared to the needle in a haystack, PCR is the technique that first makes many copies of the needle before the haystack is searched. This "amplification" of the number of copies of the needle or piece of HIV is an in vitro reaction that is performed on the nucleic acid derived from the clinical specimen.

The ultimate use(s) of PCR for the detection of HIV will be determined once ongoing studies have established the relevance of PCR test findings to clinical status. It is hoped that PCR tests will be useful in the early detection of HIV infection in newborns, where serodiagnosis is complicated by the presence of the mother's antibodies. Other prospects are that PCR tests might be useful in the resolution of infection status of adult and pediatric patients whose serodiagnosis is indeterminate, or for the early (preseroconversion) detection of HIV in adults at risk. It is important to note that the Association of State and Territorial Public Health Laboratory Directors (ASTPHLD) current recommendation is that PCR should only be used as part of a controlled research study and that results of PCR analysis should not be used to determine therapy (ASTPHLD, Fifth Consensus Conference, 1990). Further evaluation of various risk group populations are needed to better define the correlation between PCR result and infection status. Until such correlations can be firmly established and standards for PCR testing rigorously enforced, routine testing of individuals is not recommended.

PCR offers promise as a future means to clinically diagnose HIV infection. But any new diagnostic technology such as PCR has its limitations; the PCR test is only in the preliminary phase of evaluation and is not yet standardized. Thus it may be possible to obtain different PCR results from different laboratories on the same specimen. PCR testing is not yet quality controlled; therefore, laboratories doing PCR are not required to test standard controls and report these results to a central quality control office.

Additional issues related to clinical PCR testing that must be addressed, include the possibility that HIV-PCR positive results may be observed to be linked to some latent HIV infections that will not lead to AIDS. Alternatively, it is possible that an HIV-PCR negative result would be observed to be linked to an infection that is present but undetectable due to either a low virus load or a poor specimen preparation. Only longer term followup and extensive study correlating laboratory and clinical indicators of disease will determine the relevance of PCR findings to clinical diagnosis and prognosis.

Due to the above-mentioned reasons, the FDA will not license any research or clinical laboratories to perform PCR testing until the on-going PCR correlation studies are completed and evaluated. Several commercial laboratories have been granted a patent license by Cetus Corporation, which means that only those who have permission from Cetus and have a Cetus patent license are allowed to charge a fee for PCR tests that are performed as part of their research. Such licenses do not signify that the testing performed has been fully evaluated.

For more information on PCR studies please call Dr. Anne Comeau at (617) 522-3700, Ext. 158.

CALENDAR

WEDNESDAY, July 11, 1990, ADOLESCENT AIDS NETWORKING BREAKFAST
9:00-10:00 AM. Club Cafe, Columbus Avenue at East Berkley Street, Boston. The Adolescent AIDS Networking Breakfasts are held on the first Wednesday of each month. For more information please call Shoshana Rosenfeld at (617) 727-0368.

AIDS NETWORKING BREAKFAST
There will be no meetings during the months of July, and August. The AIDS Networking Breakfasts will resume in September. For more information please call Ann Sanders at 725-3485 or Rhoda Johnson at (617) 424-4559.

MONDAY-WEDNESDAY, AUGUST 6-8, 1990, THE FOURTH INTERNATIONAL CONFERENCE ON AIDS
This interdisciplinary educational conference focuses on 'Challenges and Choices for the 90s' in approaches to prevention and control of AIDS. It will take place at the El Juan Hotel, San Juan, Puerto Rico. For more information, contact Donna L. Richter, Ed.D., University of South Carolina, School of Public Health, Colombia, SC, 29208. Telephone (803) 777-4845.

CORRECTION TO APRIL 1990 NEWSLETTER
On the second page the numbers for Massachusetts transmission categories, sex, mortality, race, and age were listed for Massachusetts residents only (N=2774). These categories should list numbers for residents and nonresidents. The May 1990 Newsletter has the correct numbers for residents and nonresidents.

A Publication of the AIDS Surveillance Program

George R. Seage III **Jeanne Day** **Stephanie Oddleifson**
Laurie Kunches **Beverly Heinze-Lacey** **Laurie Makarewicz**

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GOVERNMENT DOCUMENTS COLLECTION

AIDS NEWSLETTER

a monthly publication from the
Massachusetts Department of Public Health/Boston Department of Health and Hospitals

Vol. 6 June, 1990 No. 6

UPDATE

During June, a total of sixty-three AIDS cases were reported to the Massachusetts AIDS Surveillance Program. As of July 1, 1990, the AIDS Surveillance Programs at the Massachusetts Department of Public Health and the Boston Department of Health and Hospitals will be consolidated at the State Laboratory Institute.

All Boston and non-Boston AIDS cases should be reported to any of the following surveillance epidemiologists: Eileen Carr, Laurie Makarewicz, Stephanie Oddleifson, Barbara Shea, or Minka vanBeuzekom, at (617) 522-3700, Ext. 478 or Ext. 482.

MASSACHUSETTS RESIDENT CASES AND CUMULATIVE INCIDENCE RATES BY COUNTY

COUNTY	NUMBER	%MA CASES	CASES PER MILLION
Berkshire	21	0.8	144.7
Bristol	118	4.3	248.6
Cape and Islands	134	4.8	854.2
Essex	166	6.0	262.0
Franklin	13	0.5	202.1
Hampden	130	4.7	293.4
Hampshire	20	0.7	144.1
Middlesex	444	16.0	324.8
Norfolk	164	5.9	270.4
Plymouth	114	4.1	281.2
Suffolk	1318	47.5	2027.2
Worcester	131	4.7	202.7
TOTAL	2774	100	483.5

For case reporting of AIDS patients meeting the CDC definition , please notify AIDS Epidemiologists at (617) 424-4377 (in Boston) or (617) 522-3708 ext. 482 (outside Boston).

AIDS SURVEILLANCE SUMMARY: STATE AND NATIONAL COMPARISONS

Total Cases as of 6/01/90	Massachusetts (3,160)*		United States (132,510)**	
	No.	(%)	No.	(%)
Residence				
City of Boston	1,303	(42)		
Remainder SMSA	739	(23)		
Remainder State	876	(27)		
Subtotal 2,918				
Out-of-State	242	(8)		
Transmission Categories (Adults)	3,091		130,252	
Homosexual/Bisexual Male	1,868	(60)	78,212	(59)
I.V. Drug User	592	(19)	27,842	(21)
Homosexual Male/I.V. Drug User	128	(4)	8,948	(7)
Hemophilia	46	(1)	1,171	(<1)
Heterosexual Cases***	270	(9)	6,532	(5)
Transfusion Blood/Components	87	(3)	3,119	(2)
None of the Above	100	(3)	4,421	(3)
Transmission Categories (<13 yrs)	69		2,258	
Parent with AIDS/at risk for AIDS	61	(88)	1,863	(83)
Hemophilia	2	(3)	114	(5)
Transfusion, Blood/Components	6	(9)	226	(10)
None of the above	0	(0)	55	(2)
Sex				
Male	2,813	(89)	118,016	(90)
Female	347	(11)	12,236	(10)
Condition				
Alive	1,360	(43)	51,711	(39)
Dead	1,800	(57)	80,799	(61)
Race				
White	2,187	(69)	73,746	(56)
Black	624	(20)	36,682	(28)
Hispanic	328	(10)	20,765	(16)
Other/Unknown	21	(<1)	1,317	(<1)
Age				
Under 13	69	(2)	2,258	(2)
13-19	15	(<1)	513	(<1)
20-29	644	(20)	26,870	(20)
30-39	1,539	(49)	61,170	(46)
40-49	655	(21)	28,264	(21)
over 49	238	(8)	13,435	(10)

---

*Includes 510 cases meeting the revised case definition.

**Total Cases as of 4/30/90.

***Includes 114 persons who have had heterosexual contact with high risk individuals and 156 persons without other identified risks who were born in countries in which heterosexual transmission is believed to play a major role.

TUBERCULOSIS AND HIV: THE CONNECTION

An increase in tuberculosis (TB) cases has occurred in some states from 1985 through 1989, frequently in proportion to the rise in AIDS cases. This rise in TB is almost certainly related to coinfection by TB and Human Immunodeficiency Virus (HIV). The impact of the increases in TB in some states upon national averages has been sufficient to reverse the overall declines seen in earlier times (see MMWR 12/01/89. Vol. 38, No. 47).

In Massachusetts, the reversal in the traditional annual decline in TB cases, first noted in 1987, accelerated in 1989 when 10% more cases were reported than in 1988 (421 new cases in 1989 compared to 382 cases in 1988). The evidence that full-blown AIDS or HIV infection is contributing to the resurgence of TB in Massachusetts is available from two sources: TB/AIDS registry matching and TB clinic serosurvey data. A review of entries of individuals appearing in the TB registry and the AIDS registry revealed that during the period from 1982-1989 there were 143 persons appearing in both registries: a total of 77 (54%) are Boston residents, and another 31 (22%) reside in the Boston Standard Metropolitan Statistical Area.

An unlinked HIV serologic study performed in selected patients with known (Class 3) or suspected (Class 5) TB has revealed that 27% of the 188 tested since June 1988 in a group of TB patients in Boston were HIV positive. Age, sex, and racial breakdowns of the HIV seropositives are presented in the table below. A greater proportion of the positives were less than 40 years of age (78%); males were more likely to be positive than females (84% vs 16%); and blacks bear a disproportionate burden of the positives (68%). Because recruitment sites are limited, the data is subject to selection bias. The TB clinic serosurvey has been expanded to include additional sites: more complete data will be available in the future.

Health care providers and facilities that care for persons known to be infected with or at risk for HIV infection are strongly encouraged to include TB testing as part of routine health care. In adults at risk for immunosuppression, TB testing should be performed annually, and more frequently if known exposure to an active case occurs or if clinical symptoms in an individual suggest TB. All confirmed or suspected cases of active TB should be reported without delay to the town or city health department where the client resides.

Mantoux testing with PPD is the test of choice. New guidelines on the interpretation of skin tests have recently been released by the CDC. Of note is that induration of >5 mm should be considered a significant response in persons who are immunosuppressed, including those with HIV infection. A 5 mm cutoff is also recommended for IVDU even if their HIV status is unknown: a high risk of HIV/TB has been demonstrated in this group. Intravenous drug users and persons infected with HIV are also more likely to be anergic: thus, anergy testing (using at least two common antigens) is indicated if tuberculosis is suspected.

Current CDC guidelines also recommend HIV testing for all cases of active TB (Class 3 TB), as well as for all persons infected with tuberculosis (Class 2 TB) who are at risk of HIV infection. HIV testing is available at 30 Massachusetts TB clinics statewide.

In-service training on TB and TB/HIV can be arranged through the Massachusetts Department of Public Health Division of TB Control, or for Boston residents - the Boston City Health Department. Medical evaluation for TB and anti-TB medications are provided free of charge at designated TB Clinics statewide, including the TB clinic at Boston City Hospital (which is open 5 days a week). In Boston, for sites that have a significant number of clients with or at risk for HIV, resources are available to provide on-site TB nursing follow-up, including client education, and distribution and monitoring of anti-TB medications.

For further information or to arrange TB-related services outside Boston please contact Sue Etkind, Director of the Division of TB Control (617-522-3700, Ext. 450); in Boston, please contact Carolyn Murray, TB Control Supervisor (617-534-4585) or Anita Barry, Director of Communicable Disease Control, Boston Department of Health and Hospitals (617-534-5916).

CHARACTERISTICS OF A SAMPLE OF TB CLINIC PATIENTS (CLASS 3 & 5)
INCLUDING THOSE WHO ARE HIV POSITIVE

CATEGORY	TOTAL TB (CLASS 3 & 5) N=188		HIV POSITIVES N=50	
	Number	(%)	Number	(%)
Age				
<40	112	(60)	39	(78)
>40	76	(40)	11	(22)
Sex				
Male	132	(70)	42	(84)
Female	56	(29)	8	(16)
Race				
Black	101	(54)	34	(68)
Hispanic	24	(13)	8	(16)
White	29	(15)	7	(14)
Other/Unknown	34	(18)	1	(2)

CALENDAR

WEDNESDAY, AUGUST 1, 1990, ADOLESCENT AIDS NETWORKING BREAKFAST
9:00-10:00 AM. Club Cafe, Columbus Avenue at East Berkley Street, Boston. The Adolescent AIDS Networking Breakfasts are held on the first Wednesday of each month. For more information please call Shoshana Rosenfeld at (617) 727-0368.

AIDS NETWORKING BREAKFAST
There will be no meetings during the months of July, and August. The AIDS Networking Breakfasts will resume in September. For more information please call Ann Sanders at 725-3485 or Rhoda Johnson at (617) 424-4559.

MONDAY-WEDNESDAY, AUGUST 6-8, 1990, THE FOURTH INTERNATIONAL CONFERENCE ON AIDS
This interdisciplinary educational conference focuses on Challenges and Choices for the 90s' in approaches to prevention and control of AIDS. It will take place at the El Juan Hotel, San Juan, Puerto Rico. For more information, contact Donna L. Richter, Ed.D., University of South Carolina, School of Public Health, Colombia, SC, 29208. Telephone (803) 777-4845.

A Publication of the AIDS Surveillance Program

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AIDS NEWSLETTER

A MONTHLY PUBLICATION OF THE
Massachusetts Department of Public Health

Vol. 7 January, 1991 No. 1

MAR ... 1991

UPDATE

During December 1990, a total of sixty-nine AIDS cases were reported to the Massachusetts AIDS Surveillance Program. In the table below nine out of the ten Massachusetts Standard Metropolitan Statistical Areas (SMSAs) are listed with their respective AIDS case numbers and rates. The Pittsfield SMSA is excluded from this table because of the relatively small number of cases (16 cases) reported from this SMSA.

AIDS IN MASSACHUSETTS
STANDARD METROPOLITAN STATISTICAL AREA (SMSA) DATA
As of January 1, 1990

SMSA	BOSTON	BROCKTON	FALL RIVER	FITCHBURG	LAWRENCE	LOWELL	NEW BEDFORD	SPRINGFIELD	WORCESTER	ALL
Population	2,763,357	169,374	145,963	99,957	231,223	225,320	169,425	522,195	372,940	4,699,754
Communities*	92	8	5	6	11	7	8	23	25	185
Total Cases	2,314	87	27	23	74	66	106	209	118	3,024
Rate/100,000	83.7	51.4	18.5	23.0	32.0	29.3	62.6	40.0	31.6	64.3
SEX:										
Male	90%	86%	85%	87%	91%	89%	73%	81%	81%	88%
Female	10%	14%	15%	13%	9%	11%	27%	19%	19%	12%
RACE:										
White	66%	55%	96%	57%	58%	64%	58%	52%	57%	64%
Black	25%	33%	4%	9%	4%	12%	10%	23%	18%	23%
Latino	8%	11%	-	35%	38%	24%	31%	24%	21%	12%
Other	1%	-	-	-	-	-	-	1%	4%	<1%
RANSMISSION:										
Homo/bisexual	61%	37%	41%	48%	45%	45%	24%	34%	42%	55%
IVDU	17%	38%	26%	43%	32%	27%	55%	40%	34%	22%
Homo & IVDU	3%	7%	4%	0%	3%	5%	3%	5%	6%	4%
Heterosexual	10%	9%	4%	4%	5%	3%	8%	5%	8%	9%
Other**	8%	9%	26%	4%	15%	20%	10%	15%	11%	9%
EAN AGE AT DX:	35.3	35.5	37.7	33.2	34.4	34.8	35.2	34.1	35.4	35.0

Note: Rates may be unstable due to small numbers

Number of communities included in the SMSA
* Includes hemophiliacs, transfusion-related, pediatric and undetermined cases

For case reporting of AIDS patients meeting the CDC definition, please notify AIDS Epidemiologists at (617) 522-3700, ext. 482 or 476.

AIDS SURVEILLANCE SUMMARY: STATE AND NATIONAL COMPARISONS

Total Cases as of 01/01/91	Massachusetts Cases (3,661) No. (%)	United States Cases * (154,917) No. (%)
Residence		
City of Boston	1,470 (40)	
Remainder SMSA	844 (23)	
Remainder State	1,081 (30)	
Subtotal	3,395	
Out-of-State	266 (7)	
Transmission Categories (Adults)	3,579	152,231
Homosexual/Bisexual Male	2,105 (59)	90,599 (60)
I.V. Drug User	744 (21)	33,000 (22)
Homosexual Male/I.V. Drug User	150 (4)	10,215 (7)
Hemophilia	48 (1)	1,344 (1)
Heterosexual Cases**	307 (9)	8,018 (5)
Transfusion, Blood Components	100 (3)	3,572 (2)
None of the Above	125 (3)	5,483 (4)
Transmission Categories (<13 yrs)	82	2,686
Parent with AIDS/at risk for AID	72 (88)	2,233 (83)
Hemophilia	3 (0)	136 (5)
Transfusion, Blood/Components	7 (0)	250 (9)
None of the Above	0 (0)	67 (2)
Sex		
Male	3,242 (89)	138,863 (90)
Female	419 (11)	16,054 (10)
Condition		
Alive	1,479 (40)	59,143 (38)
Dead	2,182 (60)	95,774 (62)
Race		
White	2,493 (68)	85,129 (55)
Black	737 (20)	43,656 (28)
Latino	402 (11)	24,545 (16)
Other/Unknown	29 (1)	1,587 (1)
Age at Initial Dx. (yrs.)		
<13	82 (2)	2,686 (2)
13-19	15 (0)	604 (0)
20-29	761 (21)	31,176 (20)
30-39	1,782 (49)	71,288 (46)
40-49	749 (20)	33,467 (22)
50+	272 (7)	15,696 (10)

* Total cases as of 12/01/90

** Includes 139 persons who have had heterosexual contact with high risk individuals and 168 persons without other identified risks who were born in countries in which heterosexual transmission is believed to play a major role.

DEVELOPING AIDS/HIV SERVICES

The Massachusetts Department of Public Health recently released a report which summarized the state's need for AIDS and HIV related services through 1994. The report "Developing AIDS/HIV Services in Massachusetts - A Blueprint for Action 1990 - 1994," was the product of a year long collaborative effort of community organizations, clinical experts, and state health and social service planners. The project, Mobilizing Organizations for Victory over the Epidemic of AIDS, (M.O.V.E.), was primarily intended to build and integrate HIV services in 'low' prevalence areas of the state, defined as those areas outside of Metropolitan Boston. The final document however, includes projections for Metro Boston as well.

The M.O.V.E. report projects that as many as 36,000 Massachusetts residents will be infected with HIV by the end of 1994. By that time more than 9,000 residents will have been diagnosed with AIDS, and more than half of these individuals will have died. The estimates of HIV-infected persons and AIDS cases were derived from a combination of calculations looking at several different data sources. These methods were then applied to each of the six Health Service Areas (HSAs) of the state. These areas are: Western Massachusetts, Central Massachusetts, the Merrimack Valley, Metro Boston, Southeastern Massachusetts and the North Shore.

The majority of AIDS cases have remained among gay men, however, an increasing number of cases can be counted among intraveneous (IV) drug users, women and children. Communities of color have been especially hard hit by HIV illness. Their proportion of AIDS cases is substantially higher than the proportion of the population they represent.

The report stresses the growth of the epidemic in urban areas of the state. Not suprisingly, these are the same regions which are marked by troubling health indicators and an array of socioeconomic problems. HIV infection is intertwined with many public health problems in urban regions which creates the need for more services.

Although the AIDS epidemic in Massachusetts has evoked an enormous response by the medical, public health and social service sectors, the continued growth of the epidemic is beginning to overwhelm elements of these sectors.

The primary goal of the M.O.V.E. report is to provide planners, policy makers and advocates with a tool and reference guide in organizing HIV/AIDS related services. The M.O.V.E. report's estimates of the number of HIV-infected individuals and AIDS cases were used to calculate service projections along a continuum of the health and social service system.

Among the traditional health-related services reviewed are: testing and counseling, primary, acute and long term care, and mental health services. The strategy used in determining overall service demand was first to identify the needs of the individual and then to apply this to the aggregate of all HIV-infected individuals. In much the same way the report quantifies such needs as housing and case management. Nutrition and substance abuse services are also summarized.

Although every individual with HIV infection or AIDS faces obstacles and barriers, the report recognizes that some have additional difficulties. Therefore the report specifically addresses the unique needs of women, children, adolescents, communities of color, gay and bisexual men and IV drug users.

A final chapter looks at the issues concerning the financing of HIV services in the upcoming years. A brief review on costs and financing mechanisms is given for both Massachusetts and the nation. The emphasis is placed on both quality and cost-effective care.

The report concludes that the problems associated with HIV are not diminishing in Massachusetts. On the contrary, Massachusetts faces a formidable challenge in meeting the needs of its HIV-infected. In order to meet these needs policy makers must carefully quantify and prioritize them and then develop the most efficient and effective response. The M.O.V.E. report represents a positive step in this direction.

For a copy of the M.O.V.E. report contact Bridget Mayo at the Department of Public Health, AIDS Office, (617) 727-0368. A limited number of copies are available.

CALENDAR

Wednesday, February 6, 1991, Adolescent AIDS Networking Breakfast
9:00-10:00 A.M. Club Cafe, Columbus Avenue at East Berkley Street, Boston. The February meeting will be a potluck breakfast in honor of Shoshana Rosenfeld, previous Adolescent AIDS Coordinator. The Adolescent Networking Breakfasts are held on the first Wednesday of each month. For more information please call Pat Song at (617) 727-0368.

Wednesday, February 13, 1991, AIDS Networking Breakfast
8:00-9:00 A.M. Y.M.C.A. Stuart Room, 140 Clarendon Street in Boston. The AIDS Networking Breakfasts are held on the second Wednesday of each month. For more information please call Ann Sanders at (617) 725-3485 or Rhoda Johnson at (617) 424-4559.

Wednesday, March 6, 1991. Fourth Annual Infection Control Product and Services Exhibition of New England
9:30 A.M.-2:00 P.M. Sheraton Conference Center, Sturbridge, MA. This free exhibition sponsored by Infection Control Consultants of America will feature the latest in personal protective equipment and medical/surgical supplies designed to protect patients and health care workers from infection. In addition, various health care agencies who provide AIDS/HIV related services and education will be exhibiting. Health care professionals who would like to attend and non-profit agencies who would like to exhibit should contact Sheryl Freedland at (508) 443-0176.

ANNOUNCEMENT

Metropolitan Area HIV Service Nurse Clinician Position Available
The Metroplitan Area HIV Service (MAHS) Grant at the Boston Department of Health and Hospitals has an opening for a nurse clinician to provide direct patient care and to work with neighborhood health centers to provide training and education. Min 2 years clinical experience in AIDS care; min 5 years nursing experience. Please send resume and cover letter to: Catherine O' Connor, Department of Health and Hospitals, 1010 Massachusetts Avenue, 2nd Floor, Boston, MA 02118. Minorities are strongly encouraged to apply.

A Publication of the AIDS Surveillance Programs

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AIDS NEWSLETTER

A MONTHLY PUBLICATION OF THE
Massachusetts Department of Public Health

Vol. 7 February, 1991 No. 2

UPDATE

During January 1991, a total of one hundred and four AIDS cases were reported to the Massachusetts AIDS Surveillance Program.

CORRECTION to January 1991 Newsletter (Vol 7 No. 1) The date on the SMSA table on the first page should read January 1, 1991.

CUMULATIVE AIDS CASES BY INSTITUTION AND YEAR OF REPORT

Institution	as of 02/01/90		as of 02/01/91	
	No.	(%)	No.	(%)
Atlanticare Medical Center	10	(0.3)	13	(0.3)
Baystate Medical Center	80	(2.8)	130	(3.5)
Berkshire Medical Center	17	(0.6)	23	(0.6)
Beth Israel Hospital	217	(7.5)	271	(7.2)
Boston City Hospital	276	(9.6)	358	(9.5)
Brigham & Women's Hospital	196	(6.8)	240	(6.4)
Cambridge Hospital	21	(0.7)	36	(1.0)
Cape Cod Hospital	18	(0.6)	26	(0.7)
Carney Hospital	37	(1.3)	50	(1.3)
Charlton Memorial Hospital	18	(0.6)	23	(0.6)
Children's Hospital	37	(1.3)	50	(1.3)
Faulkner Hospital	23	(0.8)	28	(0.7)
Fenway Community Health Center	99	(3.4)	147	(3.9)
Framingham Union Hospital	14	(0.5)	18	(0.5)
Harvard Community Health Plan	97	(3.4)	118	(3.1)
Lahey Clinc	49	(1.7)	51	(1.4)
Lawrence General Hospital	14	(0.5)	22	(0.6)
Lemuel Shattuck Hospital	71	(2.5)	100	(2.7)
Massachusetts General Hospital	320	(11.1)	365	(9.7)
Mercy Hospital	12	(0.4)	33	(0.9)
Mt. Auburn Hospital	57	(2.0)	74	(2.0)
New England Deaconess Hospital	408	(14.2)	471	(12.5)
New England Medical Center	125	(4.3)	156	(4.1)
Newton-Wellesley Hospital	17	(0.6)	19	(0.5)
Quincy City Hospital	10	(0.3)	13	(0.3)
St. Elizabeth's Hospital	44	(1.5)	59	(1.6)
St. Luke's Hospital	47	(1.6)	72	(1.9)
Salem Hospital	10	(0.3)	15	(0.4)
University Hospital	50	(1.7)	56	(1.5)
Univ. of Mass Medical Center	70	(2.4)	106	(2.8)
V.A. Medical Center	64	(2.2)	80	(2.1)
Worcester City	10	(0.3)	14	(0.4)
Worcester Memorial	26	(0.9)	35	(0.9)
Other Boston Hospitals	27	(0.9)	57	(1.5)
Other Non-Boston Hospitals	288	(10.0)	436	(9.6)
TOTAL	2,879	(100)	3,765	(100)

For case reporting of AIDS patients meeting the CDC definition, please notify AIDS Epidemiologists at (617) 522-3700, ext. 482 or 478.

Completeness of AIDS Reporting in Selected Outpatient Facilities

A total of 3,675 AIDS cases have been reported as of February 1. 1991 in Massachusetts. including 1.502 cases from the city of Boston. Previous validation surveys, including death certificate reviews and use of the hospital discharge tapes, have suggested that statewide reporting of cases is approximately 93% complete. Most cases have been reported from hospitals. Only 11% of AIDS cases have been reported from outpatient sites such as clinics and community health centers. However, as the HIV epidemic progresses and health care providers become more familiar with HIV illness, the proportion of HIV-infected persons receiving care in outpatient facilities is expected to increase. Surveillance systems in many outpatient sites are not as well developed as those in hospitals, and responsibility for reporting cases falls to individual health care providers who may be unfamiliar with reporting requirements and with criteria for the Centers for Disease Control definition of AIDS.

To determine the current completeness of AIDS case reporting in various outpatient settings, we set up a surveillance system in selected Boston outpatient facilities. This article describes the outpatient study and evaluates the completeness of AIDS case reporting from these sites.

Eight sites, representing various communities in Boston, were selected and agreed to participate in the study. The length of the study period varied among facilities because we allowed for variations in case loads and the amount of baseline data from earlier reporting.

A standarized abstract form was completed for each HIV-infected individual by the staff of the outpatient facility. Information on patient demographics (age, sex, race, country of birth, zipcode and HIV risk factor), AIDS-indicator disease(s), infections, conditions both related and unrelated to HIV, treatment/prophylaxis data, tuberculosis status, laboratory results and roentgenographic data (X-ray, CAT scan, and ultrasound) were obtained. To ensure confidentiality of patients, a nonidentifying patient code and date of birth were used instead of names on the abstract forms.

To determine whether an HIV-infected individual met the criteria for AIDS, surveillance epidemiologists reviewed the abstract forms. Using the nonidentifying patient code and date of birth, the outpatient database was matched to the statewide AIDS case registry to determine what proportion of cases had previously been reported and how many represented unreported AIDS cases.

The eight outpatient sites submitted over 300 abstracts on over 100 HIV-infected individuals. Only a minority of HIV-infected persons fulfilled CDC criteria for AIDS. The 24 AIDS cases that did not meet the CDC criteria are now being characterized to determine how they may differ from the typical case(s) in Boston as a whole; results will be reported separately.

The lack of documentation for certain laboratory data and patient HIV risk information was a frequent problem for the chart abstracters during the review of medical records. This information is understandably viewed as sensitive and confidential but a systematic review or study of HIV illness is impeded without accurate clinical and social information. One disturbing trend seen in the study population was the high percentage of patients who missed follow-up appointments and who transferred care between health care facilities. Over 50% of the study cohort discontinued care at the health center where they had initially tested positive for HIV. Some patients transferred to another health care provider, some moved away from Boston and others were imprisoned. However, the majority of patients who discontinued care simply did not return for follow-up appointments, and their whereabouts are unknown.

This preliminary data indicate that the level of AIDS case reporting from selected outpatient facilities is over 80% complete. Active outpatient AIDS surveillance activities are needed to ensure completeness of AIDS case reporting and to monitor the anticipated increase in patients seeking HIV related health care in outpatient clinics and neighborhood health centers. Some data suggest that this increase in care delivered in outpatient sites is already occurring in Massachusetts and other parts of the country. In 1987, Massachusetts outpatient cases made up only 6% of diagnosed cases compared to 16% of diagnosed cases in 1989.

The number of HIV-infected people in Massachusetts is estimated to be between 25,000 to 35,000. With the cost of health care escalating, there is a need for a network of providers who can provide compassionate cost effective care for patients with HIV infection and AIDS at outpatient facilities. As hospitals become more overburdened, outpatient facilities are likely to play an increasing role in the delivery of HIV-related care. Active AIDS surveillance at outpatient sites will be needed to ensure that this level of reporting continues.

AIDS SURVEILLANCE SUMMARY: STATE AND NATIONAL COMPARISONS

Total Cases as of 02/01/91	Massachusetts Cases (3,765)	United States Cases * (161,073)
	No. (%)	No. (%)
Residence		
City of Boston	1,502 (40)	
Remainder SMSA	873 (23)	
Remainder State	1,117 (30)	
Subtotal	3,492	
Out-of-State	273 (7)	
Transmission Categories (Adults)	3,680	158,287
Homosexual/Bisexual Male	2,169 (59)	94,126 (59)
I.V. Drug User	762 (21)	34,398 (22)
Homosexual Male/I.V. Drug User	151 (4)	10,557 (7)
Hemophilia	49 (1)	1,386 (1)
Heterosexual Cases**	319 (9)	8,440 (5)
Transfusion, Blood Components	102 (3)	3,684 (2)
None of the Above	128 (3)	5,696 (4)
Transmission Categories (<13 yrs)	85	2,786
Parent with AIDS/at risk for AID	74 (87)	2,327 (84)
Hemophilia	4 (0)	139 (5)
Transfusion, Blood/Components	7 (0)	252 (9)
None of the Above	0 (0)	68 (2)
Sex		
Male	3,330 (88)	144,295 (90)
Female	435 (12)	16,778 (10)
Condition		
Alive	1,512 (40)	60,260 (37)
Dead	2,253 (60)	100,813 (63)
Race		
White	2,565 (68)	88,342 (55)
Black	753 (20)	45,466 (28)
Latino	416 (11)	25,649 (16)
Other/Unknown	31 (1)	1,616 (1)
Age at Initial Dx. (yrs.)		
<13	85 (2)	2,786 (2)
13-19	15 (0)	629 (0)
20-29	777 (21)	32,354 (20)
30-39	1,838 (49)	74,027 (46)
40-49	773 (21)	34,989 (22)
50+	277 (7)	16,288 (10)

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* Total cases as of 01/01/91

** Includes 143 persons who have had heterosexual contact with high risk individuals and 176 persons without other identified risks who were born in countries in which heterosexual transmission is believed to play a major role.

CALENDAR

Wednesday, March 6, 1991, Adolescent AIDS Networking Breakfast
9:00-10:00 A.M. Club Cafe, Columbus Avenue at East Berkley Street, Boston. The March speaker will b Dr. Maxine Rawlins, the Director of Development at the Dorchester Counseling Center. A video abou adolescent drug use, violence, and prevention activities, "A Second Chance", will be shown and discussed The Adolescent Networking Breakfasts are held on the first Wednesday of each month. For mor information please call Pat Song at (617) 727-0368.

Wednesday, March 13, 1991, AIDS Networking Breakfast
8:00-9:00 A.M. Y.M.C.A. Stuart Room, 140 Clarendon Street in Boston. The AIDS Networking Breakfast are held on the second Wednesday of each month. For more information please call Ann Sanders a (617) 725-3485 or Rhoda Johnson at (617) 424-4559.

ANNOUNCEMENT

"HIV and AIDS in the Dental Setting: A Faculty Development Program for Dentists and Dental Hygienists"
May 2-4, 1991, in South Yarmouth, MA. This is a federally funded program to whose goal is to improve the ability of dental health care providers to appropriately diagnose, treat, and care for people with HIV/AIDS. The course will be offered without charge except for a registration fee of $75.00 to cover food and course materials. CEUs will be given. For an application please call Jo-ann Shepard at UMASS Medical Center, Worcester, MA, (508) 856-3255.

IN MEMORIUM

On Monday, February 11, 1991, E. Duane Draper, Director of the Massachusetts Department of Public Health's AIDS Program, died after a long and courageous battle with AIDS. Despite his own illness, Duane continued to be a powerful advocate for individuals with HIV/AIDS throughout the state. He was responsible for significant Public Health campaigns to stop the spread of the HIV/AIDS epidemic. His dedication has made a tremendous difference in the lives of his friends and colleagues and he will be missed by many. Contributions can be made to the E. Duane Draper Scholarship Fund, P.O. Box 391115, Cambridge, MA 02139.

A Publication of the AIDS Surveillance Programs

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AIDS NEWSLETTER

Vol 7 No. 3 Monthly publication of the Massachusetts Department of Public Health March, 1991

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PARTNER NOTIFICATION

The Massachusetts Department of Public Health Division of Sexually Transmitted Disease (STD) Control has used partner notification and referral as an effective disease intervention tool for decades. The mission of the STD/HIV Partner Notification and Referral Program is to provide voluntary and confidential notification and referrals to individuals exposed to HIV infection. Partner notification promotes rapid disease prevention through educational and disease control efforts targeted to individuals at risk for HIV infection who are unknowing and uninformed of their risk.

WHAT IS PARTNER NOTIFICATION AND REFERRAL?

Partner notification is a voluntary strictly confidential process by which persons exposed to a STD are informed of their exposure and offered access to medical evaluation and treatment. It has been used successfully by public health officials for more than 40 years to reduce morbidity and mortality from STDs.

IS PARTNER NOTIFICATION COMPATIBLE WITH CONFIDENTIALITY?

Yes. Confidentiality is vital to the continued success of partner notification efforts. The sensitive and highly personal nature of STD/HIV information demands it. If partner notification programs could not assure strict confidentiality of information volunteered to them by patients, the harm to individuals and to community trust in disease control programs would have already resulted in program extinction. Instead, there exists a long-standing record of health department performance in protecting patient confidentiality. All partner notification activities are carried out in private and in person.

ISN'T IT NECESSARY TO REVEAL A PATIENT'S IDENTITY IN THE PROCESS OF INFORMING THAT PERSON'S PARTNER OF POTENTIAL EXPOSURE?

No. An infected person's identity is never revealed or acknowledged in STD partner notification. The measures taken to preserve confidentiality are what make the process work.

CAN PARTNER NOTIFICATION WORK IN AN ANONYMOUS HIV COUNSELING AND TESTING SETTING?

Yes. During the pre-and post-test HIV counseling sessions the issue of notifying partners is discussed. If the client chooses to use the partner notification system, there are two options: the first option, "partner referral", occurs when the client notifies the partner. The counselor's role in this process is to advise the client on how to inform the partner in a sensitive manner with the goal of encouraging the partner to seek medical attention. A second process, "partner notification", occurs when the Health Department Disease Intervention Specialist performs the notification service at the request of the client. In the former process, neither the client nor the partner need to be identified by name, and in the latter process, the client is not named to the partner.

CAN PARTNER NOTIFICATION TO PREVENT HIV TRANSMISSION WORK AS IT DOES FOR OTHER STDs FOR WHICH CURATIVE TREATMENT IS AVAILABLE?

Yes. Education is the reason why partner notification should be part of the HIV prevention efforts. This process can help reach people with very real and often continuing risk for HIV infection who exhibit denial or are unaware of their risk. Education can reach persons who have been unaffected by educational messages that seem abstract and impersonal. Getting information on HIV/AIDS prevention to persons who are unaware of their risk, and who could do something differently based on that information to protect themselves and others, is the point of partner notification.

IS THE CONFIDENTIALITY OF RECORDS PROTECTED BY LAW?

Yes. Every state has a statute protecting the confidentiality of STD records. In Massachusetts, they are protected against public release, unauthorized access, or subpoena by Chapter 111, Section 119 of Massachusetts General Laws. In addition, unauthorized disclosure of HIV antibody test results (or even the fact of test performance) is prohibited by Chapter 111, Section 70F of Massachusetts General Laws.

WHAT HAPPENS TO INFORMATION THAT IDENTIFIES PARTNERS ONCE THEY HAVE BEEN NOTIFIED?

The public health value of this information ends when a partner has been notified, or at the point when a partner cannot be located. Only aggregate, nonidentifying data are retained. All individual records generated by a partner notification program for HIV infection are destroyed after a partner has been informed of exposure or when the partner cannot be notified.

WHAT IS A SUCCESSFUL PARTNER NOTIFICATION ENCOUNTER?

A successful encounter empowers an HIV-infected client to participate in actual disease prevention.

-The infected client receives focused risk reduction information and immediate referral to appropriate health care resources to initiate early medical intervention.

-Named partners of the client are offered counseling, testing and

(CONT ON BACK PAGE)

AIDS SURVEILLANCE SUMMARY: STATE AND NATIONAL COMPARISONS

Total Cases as of 03/01/91	Massachusetts Cases (3,840) No. (%)	United States Cases * (167,803) No. (%)
Residence		
City of Boston	1,515 (39)	
Remainder SMSA	887 (23)	
Remainder State	1,162 (30)	
Subtotal	3,564	
Out-of-State	276 (7)	
Transmission Categories (Adults)	3,753	164,900
Homosexual/Bisexual Male	2,199 (59)	97,687 (59)
I.V. Drug User	785 (21)	36,155 (22)
Homosexual Male/I.V. Drug User	152 (4)	10,916 (7)
Hemophilia	52 (1)	1,434 (1)
Heterosexual Cases**	332 (9)	8,907 (5)
Transfusion, Blood Components	102 (3)	3,787 (2)
None of the Above	131 (3)	6,014 (4)
Transmission Categories (<13 yrs)	87	2,903
Parent with AIDS/at risk AIDS	76 (87)	2,433 (84)
Hemophilia	4 (5)	145 (5)
Transfusion, Blood/Components	7 (8)	255 (9)
None of the Above	0 (0)	70 (2)
Sex		
Male	3,387 (88)	150,128 (89)
Female	453 (12)	17,675 (11)
Condition		
Alive	1,504 (39)	61,442 (37)
Dead	2,336 (61)	106,361 (63)
Race		
White	2,611 (68)	91,654 (55)
Black	770 (20)	47,603 (28)
Latino	427 (11)	26,853 (16)
Other/Unknown	32 (1)	1,693 (1)
Age at Initial Dx. (yrs.)		
<13	87 (2)	2,903 (2)
13-19	15 (0)	659 (0)
20-29	791 (21)	33,568 (20)
30-39	1,877 (49)	77,117 (46)
40-49	785 (20)	36,547 (22)
50+	285 (7)	17,009 (10)

---

* Total cases as of 03/01/91

** Includes 151 persons who have had heterosexual contact with high risk individuals and 181 persons without other identified risks who were born in countries in which heterosexual transmission is believed to play a major role.

MASSACHUSETTS RESIDENT CASES
AND CUMULATIVE INCIDENCE RATES BY COUNTY

COUNTY	NUMBER	%MA CASES	CASES PER MILLION
Berkshire	29	0.8	199.8
Bristol	177	5.0	372.9
Cape and Islands	166	4.6	1,047.8
Essex	209	5.9	329.8
Franklin	19	0.5	295.4
Hampden	215	6.0	485.3
Hampshire	29	0.8	208.9
Middlesex	568	15.9	415.5
Norfolk	216	6.1	356.1
Plymouth	157	4.4	387.2
Suffolk	1,586	44.5	2,439.5
Worcester	193	5.4	298.6
TOTAL	3,564	100	621.2

CALENDAR

Wednesday, April 10, 1991, AIDS Networking Breakfast
8:00-9:00 A.M. Y.M.C.A. Stuart Room, 140 Clarendon Street, Boston. The AIDS Networking Breakfasts are held on the second Wednesday of each month. For more information please call Ann Sanders at (617) 725-3485 or Rhoda Johnson at (617) 424-4559.

Wednesday, May 29, 1991, "AIDS, HIV and the Dental Professional"
9:00 A.M.-5:00 P.M. A day long education program for dentists and dental hygenists will be held in Framingham. For exact location and more information please call Louise Rice at (617) 437-6200, Ext. 264 or Christie Burke at (617) 727-0368.

HIV clinical training for physicians and mid-level practitioners is available through a grant from the AIDS Education and Training Center. The training program is a collaborative effort with the AIDS Service Demonstration Project; training can be arranged at several community provider sites that have extensive HIV and AIDS experience. The mini-clinical residencies can be arranged for one or two days at one or two sites. To arrange for a training session please contact:

-Lee Swislow, R.N., AIDS Coordinator, The Cambridge Hospital. (617) 498-1212.

-Beverly Wancho, R.N., AIDS Coordinator, Visiting Nurses of Boston. (617) 577-7900, Ext. 250.

-Catherine O'Connor, N.P., Diagnostic & Evaluation Unit. Beeper 1-800-212-3255.

-Connie Hagerty, R.N., AIDS Unit, Mattapan Hospital. (617) 298-7900.

For more information on these training sessions please call Eugenia Handler, Coordinator, at (617) 267-0900.

(CONT. FROM PAGE ONE)

focused risk reduction education. No partner is forced to be tested.

HOW DOES ONE ACCESS STD/HIV PARTNER NOTIFICATION SERVICES?

Call your local STD Program or STD Clinic

Boston:	(617) 522-3700 ext 403
Southeast MA:	(508) 947-1231 ext 575
Northeast MA:	(508) 851-7261 ext 670
Worcester:	(508) 799-5307
Springfield:	(413) 784-3846
Pittsfield:	(413) 443-1619

BOSTON

For case reporting of AIDS patients meeting the CDC definition, please notify AIDS Epidemiologists at (617)522-3700, ext 482 or 478

Volume 7 March, 1991 No.3

A Publication of the AIDS Surveillance Programs

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AIDS NEWSLETTER

Vol 7 No 4 *Monthly Publication of the Massachusetts Department of Public Health* *April, 1991*

WOMEN AND HIV INFECTION IN MASSACHUSETTS

PART I. AIDS Cases

The picture of the AIDS and HIV epidemic in the United States is a dynamic one that continues to change over time. In the early stages of the epidemic, white homosexual men, presenting with diseases such as Kaposi's Sarcoma and Pneumocystis carinii pneumonia (PCP) accounted for most of the reported cases of AIDS. Within a few years, the immunocompromising infection was being diagnosed in hemophiliacs and transfusion recipients; again primarily men. Now, ten years after the first reports of AIDS, more and more cases of the disease are being reported among women. As this trend continues, it is important to analyze the epidemic in women in order to plan AIDS-related disease control strategies as well as health and social services necessary in this population. Information from AIDS surveillance registries, voluntary counseling and testing programs, and blinded and unblinded HIV seroprevalence surveys can assist in presenting a picture of the progression of the HIV epidemic in women. This article will summarize our current knowledge about women with AIDS in Massachusetts.

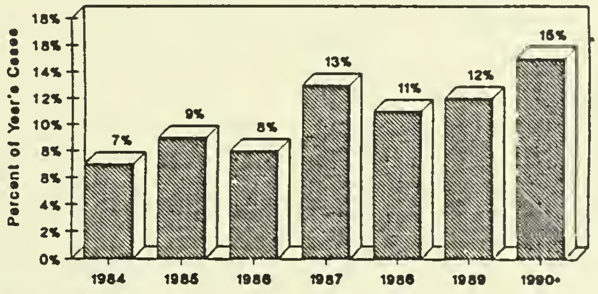
Reporting of AIDS cases has been mandated in Massachusetts since 1983. Because AIDS is the clinical endpoint of the continuum of infection with Human Immunodeficiency Virus (HIV), AIDS surveillance data provides us with information about transmission patterns as they occurred 10 years or more in the past. This data provides a rough picture of how the AIDS epidemic is changing over time, but it does not give us any information on current HIV transmission patterns.

A steady trend in recent years has been the rapid rise in the number of AIDS cases reported among women. Of the 3,586 adult AIDS cases reported in Massachusetts as of April 1, 1991, 413 (12%) have been women. Although this is a small percentage of the total, the proportion of AIDS cases diagnosed in women each year has been steadily increasing. In 1984, only 7% of diagnosed AIDS cases were women; by 1990, this number had more than doubled to 15% (see Figure 1.). In the first few months of 1991, over 20% of reported cases have been women.

Inside :
- *SMSA Data ... page 2*
- *Monthly Update ... page 3*
- *Calendar ... page 4*

Next Month :
- *Part II HIV seroprevalance in women*

Trends in AIDS Diagnoses among Female Massachusetts Residents



*1990 data are incomplete due to reporting delay.

Figure 1.

Women with AIDS differ from their male counterparts with respect to certain demographic and risk factors. On average, women with AIDS tend to be younger then men. Seventy-nine percent of female AIDS cases are under the age of 40; Sixty-four percent of men with AIDS fall into this age category. Because of the long incubation period from time of infection to development of signs and symptoms of AIDS, many women in the 20-29 year old age group were probably infected during their late adolescence. Seventy percent of women with AIDS are between the ages of 20 and 39, peak years for childbearing.

Risk behaviors for acquisition of HIV infection also differ between male and female AIDS cases. While the primary risk behavior for HIV infection in men is having unsafe sex with another male, the most significant risk behavior for women is intravenous drug use (IVDU). Fifty percent of women with AIDS in Massachusetts report having used IV drugs. In addition, heterosexual contact with a "high risk" partner (i.e. person with HIV infection, IVDU, person born in pattern II country, homo/bisexual male, etc.) is reported by 37% of female AIDS cases. Of these, 56% reported that their high risk partner was an IVDU. Taken together, IVDU plays a role in HIV transmission in 70% of female cases.

Women of color bear a disproportionate burden of AIDS (Figure 2). In the 1990 census, the Massachusetts adult female population was comprised of 4% black women and 4% latinas. Of the 413 female AIDS cases reported to date, 41% are black and 17% latina. This trend is continuing over time. In 1990, 65% of female AIDS cases were seen in communities of color. (cont'd on page 2)

AIDS IN MASSACHUSETTS
STANDARD METROPOLITAN STATISTICAL AREA (SMSA) DATA
as of April 1, 1991

SMSA	Boston	Brockton	Fall River	Fitchburg	Lawrence	Lowell	New Bedford	Springfield	Worcester
Population	2,799,893	175,661	145,252	103,070	255,622	251,325	179,505	532,799	403,004
No. Communities in SMSA	92	8	5	6	11	7	8	23	25
Total AIDS Cases	2,463	101	32	30	81	72	116	248	126
Rate per 100,000 *	88.0	57.5	22.0	29.1	31.7	28.6	64.6	46.5	31.3
Gender									
Male	89%	83%	84%	77%	85%	88%	75%	80%	81%
Female	11%	17%	16%	23%	15%	12%	25%	20%	19%
Race/Ethnicity									
White	66%	53%	94%	50%	57%	67%	58%	50%	57%
Black	25%	36%	6%	10%	5%	11%	13%	22%	17%
Latino	8%	11%	0%	40%	38%	22%	29%	27%	21%
Other	1%	0%	0%	0%	0%	0%	0%	1%	4%
Transmission Category									
Homo/Bisexual	61%	34%	41%	40%	42%	44%	22%	35%	42%
IV Drug User	18%	38%	28%	54%	31%	31%	56%	41%	36%
Homo & IVDU	3%	7%	3%	0%	2%	4%	4%	5%	6%
Heterosexual	10%	14%	3%	3%	9%	3%	8%	5%	7%
Other **	8%	8%	25%	3%	16%	18%	9%	15%	10%

---

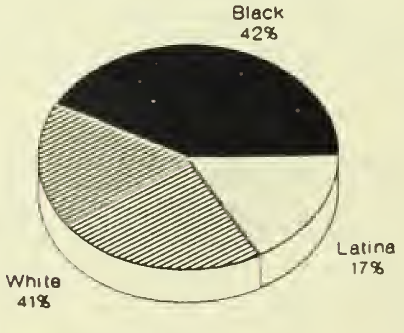
* *Population from 1990 Census.*

** *Includes hemophiliacs, blood transfusion recipients, pediatric, and undetermined risk cases.*

⊗ *Percents may not add up due to rounding.*

(Continued from page one)

Female AIDS Cases in Massachusetts by Race/Ethnicity, through 4/1/91 •



• Adult cases only (N=413)

Figure 2.

CONCLUSIONS

Analysis of AIDS Surveillance data reveals that: 1) the proportion of AIDS cases who are women is steadily increasing 2) women of color are disproportionately affected by the HIV epidemic, and 3) IVDU and heterosexual contact with high risk partners are major risk factors for acquiring HIV infection in women.

AIDS surveillance data will underrepresent HIV infection since only individuals with signs and symptoms meeting the diagnostic criteria of AIDS are included. Nevertheless, as women become increasing affected by the AIDS epidemic, educational efforts, counseling and testing services, and health care and social services will need to be directed at this population. Ongoing monitoring of AIDS surveillance and seroprevalence data will help us to target our resources in an intelligent and efficient manner.

The May 1991 AIDS NEWSLETTER will summarize information on HIV seroprevalence data in women.

AIDS SURVEILLANCE SUMMARY
STATE AND NATIONAL COMPARISONS

Total Cases as of 04/01/91		Massachusetts Cases (4,041) No. (%)	United States Cases* (171,876) No. (%)
Residence			
City of Boston		1,586 (39)	
Remainder SMSA		937 (23)	
Remainder State		1,237 (31)	
Subtotal	3,760		
Out-of-State		281 (7)	
Transmission Categories (Adults)		3,948	168,913
Homosexual/Bisexual Male		2,283 (58)	99,941 (59)
I. V. Drug User		856 (22)	37,090 (22)
Homosexual Male/ I.V. Drug User		162 (4)	11,153 (7)
Hemophilia		52 (1)	1,462 (<1)
Heterosexual Cases**		351 (9)	9,191 (5)
Transfusion, Blood Components		104 (3)	3,861 (2)
None of the Above		140 (4)	6,215 (4)
Transmission Categories (<13 yrs)		93	2,963
Parent with AIDS/at risk for AIDS		81 (87)	2,490 (84)
Hemophilia		4 (4)	146 (5)
Transfusion, Blood/Components		8 (9)	259 (9)
None of the Above		0 (0)	68 (2)
Sex			
Male		3,553 (88)	153,695 (89)
Female		488 (12)	18,181 (11)
Condition			
Alive		1,582 (39)	63,145 (37)
Dead		2,459 (61)	108,731 (63)
Race			
White		2,722 (67)	93,795 (55)
Black		824 (20)	48,841 (28)
Latino		461 (11)	27,531 (16)
Other/Unknown		34 (1)	1,709 (<1)
Age at Initial Dx (yrs.)			
<13		93 (2)	2,963 (2)
13-19		15 (<1)	670 (<1)
20-29		827 (20)	34,334 (20)
30-39		1,972 (49)	78,963 (46)
40-49		834 (21)	37,550 (22)
50+		300 (7)	17,396 (10)

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* *Total cases report as of April 1, 1991*

** *Includes 160 persons who have had heterosexual contact with high risk individuals and 191 persons without other identified risks who were born in countries in which heterosexual transmission is believed to play a major role.*

CALENDAR

Wednesday, May 29, 1991, "AIDS and the Dental Professional"
9:00 A.M.- 5:00 P.M. A full day program for Dentists and Dental Hygienists will be held at the Sheraton Tara Hotel in Framingham. For more information please call Louise Rice at (617) 437-6200, ext. 264 or Christie Burke at (617) 727-0368.

Wednesday, June 5, 1991, Adolescent Networking Meeting
9:00 A.M. - 10:00 A.M. Medical Foundation Prevention Center, 95 Berkley Street, Boston.

Wednesday, June 12, 1991, AIDS Networking Breakfast
The AIDS Networking Breakfasts are held on the second Wednesday of each month. For more information please call Ann Sanders at (617) 725-3485 or Rhoda Johnson at (617) 424-4559.

July 17-23, 1991, CDC HIV Overview: Pre and Post-Test Counseling Techniques and Seropositive Issues Course. This 5-day intensive course is geared toward providers new to the field of HIV antibody counseling and testing. The course offers demonstrations and practice counseling sessions. For more information, contact John Connors at (617) 727-0368.

Volume 7 April, 1991 No.4

A Publication of the AIDS Surveillance Programs

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AIDS NEWSLETTER

Vol 7 No 5 Monthly Publication of the Massachusetts Department of Public Health May, 1991

WOMEN AND HIV INFECTION IN MASSACHUSETTS

PART II. SEROPREVALENCE

HIV seroprevalence is defined as the presence of antibody to HIV in members of a population. It represents the amount of HIV infection present regardless of whether they have symptoms of AIDS. In combination with AIDS surveillance data, information on seroprevalence can help us to better understand current patterns of HIV transmission and to make projections about the future number of AIDS cases.

Voluntary Counseling and Testing

Women represent approximately 30% of clients voluntarily tested for HIV antibody through the Massachusetts Department of Public Health's Anonymous Test Sites (ATS) and Sexually Transmitted Disease (STD) clinics. The seropositivity rates for women being tested at ATS and STD clinics are 1.7% and 3.1% respectively. In comparison, the seropositivity rate in women tested through substance abuse treatment programs is 5.3%; 11.7% of women tested through the Department of Corrections are HIV seropositive.

Seropositivity rates for women attending ATS do not differ by age. However, in STD clinic patients, a peak seropositivity rate of 4% is seen in women aged 30-34. As with AIDS surveillance data (see April 1991 Newsletter), women of color bear a disproportionate burden of HIV infection in these counseling and testing settings. In ATS, seropositivity rates in black women and latinas were 7 and 8 percent respectively; white women had a seropositivity rate of 1%. In STD clinics, these rates were 6, 4.5, and 2 percent respectively.

In ATS, an equal number of seropositive women reported intravenous drug use (38%) as their risk behavior for acquisition of HIV infection (Figure 1). Forty-two percent of women claiming heterosexual contact as their reported having sex with an intravenous drug user (IVDU). Therefore, IVDU-related behaviors accounted for 57% of HIV infection in this population. Forty-seven percent of HIV positive women seen in STD clinics reported IVDU as their risk behavior for HIV. Heterosexual contact was reported as their primary risk by 28% of HIV-positive women; 31% of these women reported that having "multiple" sex partners was their risk for HIV infection.

Inside :

- *Institution Data* .... *page 2*
- *Monthly Update* ..... *page 3*
- *Calendar* .... *page 4*

Next Month :

- *AIDS in New England*

Serosurveys

In 1987, the Centers for Disease Control, in collaboration with state public health agencies, implemented a national surveillance system for HIV infection. Known as "the Family of HIV Seroprevalence Surveys", this system is composed of clinic-based and population-based blinded serosurveys. The purposes of the surveys were 1) to provide data on the level of HIV infection to assist in establishing educational and prevention programs, 2) to indicate changes over time in the prevalence of HIV infection, and 3) to help project the number of persons who will require medical care because of HIV infection. In addition to these surveys, the armed forces of the United States also tests all military recruits for the presence of antibody to HIV.

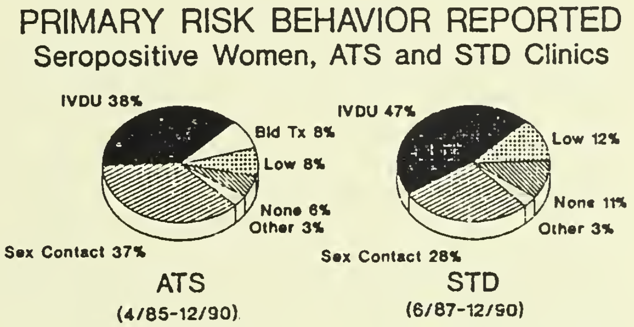

Figure 1.

Figure 2 shows the comparison of HIV seroprevalence rates among women in four serosurveys and those subject to military screening in Massachusetts. The lowest seroprevalence (0.11%) is seen in female military applicants. This low rate may be due to the policy of interviewing applicants about drug use and informing them that they will be tested for HIV, thus excluding women at highest risk from this group.

The survey of childbearing women most closely represents the general population of women in this age group (15-44). The seroprevalence rate among women in this survey was 0.24% for 1990. Women seen at three inner city women's clinics had seropositivity rates over seven times as high (1.8%) as that seen in childbearing women in Massachusetts as a whole. Seroprevalence rates in childbearing women in this urban area are also higher than the statewide average. This may reflect the greater burden of the epidemic experienced by low-income, inner city women.

CUMULATIVE AIDS CASES BY INSTITUTION AND YEAR OF REPORT

Institution	As of 5/1/90 No.	(%)	As of 5/1/91 No.	(%)
Atlanticare	11	(0.4)	24	(0.6)
Baystate Medical Center	101	(3.3)	159	(3.9)
Berkshire Medical Center	17	(0.5)	31	(0.8)
Beth Israel Hospital	227	(7.3)	275	(6.8)
Boston City Hospital	295	(9.5)	403	(10.0)
Brigham & Women's Hospital	203	(6.6)	250	(6.2)
Brockton Hospital	17	(0.5)	25	(0.6)
Cambridge Hospital	22	(0.7)	39	(1.0)
Cape Cod Community Hospital	20	(0.6)	28	(0.7)
Cardinal Cushing Hospital	11	(0.4)	12	(0.3)
Carney Hospital	37	(1.2)	51	(1.3)
Charlton Memorial Hospital	19	(0.6)	25	(0.6)
Children's Hospital	41	(1.3)	52	(1.3)
Emerson Hospital	10	(0.3)	13	(0.3)
Faulkner Hospital	25	(0.8)	29	(0.7)
Fenway Community Health Center	125	(4.0)	149	(3.7)
Framingham Union Hospital	14	(0.5)	18	(0.4)
Harvard Community Health Plan	110	(3.6)	125	(3.1)
Holyoke Hospital	9	(0.3)	14	(0.3)
Lahey Clinic	49	(1.6)	53	(1.3)
Lawrence General Hospital	15	(0.5)	24	(0.6)
Lemuel Shattuck Hospital	77	(2.5)	104	(2.6)
Massachusetts General Hospital	321	(10.4)	382	(9.5)
Mercy Hospital	20	(0.6)	37	(0.9)
Mt. Auburn Hospital	62	(2.0)	77	(1.9)
New England Deaconess Hospital	425	(13.7)	484	(12.0)
New England Medical Center	134	(4.3)	163	(4.0)
Newton-Wellesley Hospital	17	(0.5)	20	(0.3)
Quincy City Hospital	11	(0.4)	13	(0.3)
St. Elizabeth's Hospital	49	(1.6)	61	(1.5)
St. Luke's Hospital	50	(1.6)	74	(1.8)
St. Vincent's Hospital	11	(0.4)	14	(0.3)
Salem Hospital	11	(0.4)	16	(0.4)
University Hospital	52	(1.7)	61	(1.5)
Univ. of Massachusetts Medical Center	74	(2.4)	112	(2.8)
V.A. Medical Center	67	(2.2)	91	(2.3)
Worcester City Hospital	11	(0.4)	14	(0.3)
Worcester Memorial Hospital	26	(0.8)	38	(0.9)
Other Boston Hospitals	32	(1.0)	60	(1.5)
Other Non-Boston Hospitals	265	(8.6)	421	(10.4)
TOTAL	3,093	(100)	4041	(100)

Women seeking services at STD clinics had a seropositivity rate of 2.7%, eleven times as high as that seen in childbearing women. Once again, women of color are disproportionately affected by HIV and have seroprevalence rates more than double that of whites (1.3% whites, 3.4% blacks, 3.3% latina). As was demonstrated in the data from counseling and testing, IVDU accounted for a significant amount of self-reported risk behaviors. Approximately 30% of seropositive women reported this behavior. Heterosexual contact, especially with multiple partners, also accounted for a significant amount of HIV transmission in this population.

Finally, women receiving drug treatment at three surveyed centers had a seropositivity rate 70 times higher than childbearing women with a rate of 16.9%. This exemplifies the impact of IVDU on the epidemic of HIV infection.

Conclusions

HIV seropositivity rates in Massachusetts range from a low of 0.11% in female military recruits to a high of 16.9% in women receiving drug treatment. Analyses of HIV seroprevalence data from voluntary counseling and testing and serosurveys mirror that of AIDS case surveillance. Women of color are disproportionately affected by the HIV epidemic. IVDU and heterosexual contact with high risk or multiple partners are major risk factors for acquiring HIV infection in the populations studied.

Interpretation of seroprevalence data must be done with caution since the groups tested may not be representative of the general population. However, in combination with AIDS surveillance data, information on seroprevalence in women can be helpful in directing educational efforts, counseling and testing , health care and social services to those at highest risk for HIV infection.

COMPARISON OF HIV SEROPREVALENCE AMONG WOMEN IN SEROSURVEYS IN MASSACHUSETTS

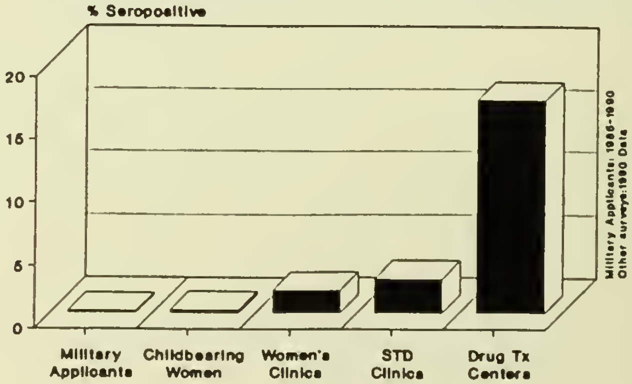

Figure 2.

AIDS SURVEILLANCE SUMMARY
STATE AND NATIONAL COMPARISONS

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Homosexual Male/ I.V. Drug User		162 (4)	11,153 (7)
Hemophilia		52 (1)	1,462 (<1)
Heterosexual Cases**		351 (9)	9,191 (5)
Transfusion, Blood Components		104 (3)	3,861 (2)
None of the Above		140 (4)	6,215 (4)
Transmission Categories (<13 yrs)		93	2,963
Parent with AIDS/at risk for AIDS		81 (87)	2,490 (84)
Hemophilia		4 (4)	146 (5)
Transfusion, Blood/Components		8 (9)	259 (9)
None of the Above		0 (0)	68 (2)
Sex			
Male		3,553 (88)	153,695 (89)
Female		488 (12)	18,181 (11)
Condition			
Alive		1,582 (39)	63,145 (37)
Dead		2,459 (61)	108,731 (63)
Race			
White		2,722 (67)	93,795 (55)
Black		824 (20)	48,841 (28)
Latino		461 (11)	27,531 (16)
Other/Unknown		34 (1)	1,709 (<1)
Age at Initial Dx (yrs.)			
<13		93 (2)	2,963 (2)
13-19		15 (<1)	670 (<1)
20-29		827 (20)	34,334 (20)
30-39		1,972 (49)	78,963 (46)
40-49		834 (21)	37,550 (22)
50+		300 (7)	17,396 (10)

* *Total cases report as of May 1, 1991*

** *Includes 160 persons who have had heterosexual contact with high risk individuals and 191 persons without other identified risks who were born in countries in which heterosexual transmission is believed to play a major role.*

Trends in Empidemiolgy of AIDS in MA — ..... *the* **FACT** *is* ..... — *MDPH AIDS Surveillance Program*

AIDS cases among women are growing at a faster pace than among men. Cases among women rose from 9% of cases diagnosed in 1985 to 15% of cases diagnosed in 1990. The 1990 incidence rate for men was three times as high as the 1985 rate, while for women it was seven times as high

CALENDAR

Wednesday, July 3, 1991, Adolescent Networking Meeting
9:00 A.M.- 10:00 A.M. Medical Foundation Prevention Center, 95 Berkeley Street, Boston. For further information call Mary Connell at (617)727-0368.

Wednesday, July 10, 1991, AIDS Networking Breakfast
The AIDS Networking Breakfasts are held on the second Wednesday of each month. For more information, please call Ann Sanders at (617) 725-3485 or Rhoda Johnson at (617)424-4559.

July 17-23, 1991, CDC HIV Overview:Pre and Post-Test Counseling Techniques and Seropositive Issues Course
This 5-day intensive course is geared toward providers new to the field of HIV antibody counseling and testing. The course offers demonstrations and practice counseling sessions. For more information contact John Connors at (617)727-0368.

September 28 - October 2, 1991 Communities Making a Difference: Serving Drug-exposed and HIV-infected Children and Their Families
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Correction to April 1991 AIDS Newsletter
Page 3: "AIDS Surveillance Summary: State and National Comparisons" the total cases reported should be as of 05/01/91.

To have an announcement listed in the AIDS Newsletter Calendar call (617)522-3700, extension 487.

AIDS NEWSLETTER

is a publication of the

AIDS Surveillacne Program

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AIDS NEWSLETTER

Vol. 7 No. 6 Monthly Publication of the Massachusetts Department of Public Health June - July, 1991

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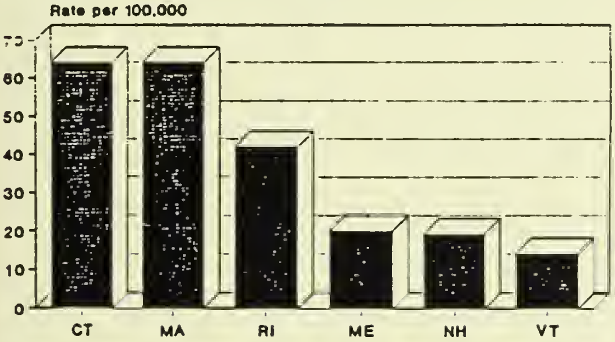
AIDS IN NEW ENGLAND

During the first decade of the epidemic, cases of AIDS have been reported predominantly in and around large metropolitan centers. Five cities, New York City, Los Angeles, San Francisco, Houston, and Washington, D.C., account for 36% of the cumulative United States * AIDS cases. The unequal geographic distribution of U.S. AIDS cases is further illustrated by the fact that 10 states (NY, CA, FL, NJ, PR, IL, PA, GA, MA and MD) have reported 73% of the cases. The gradual spread of AIDS from these population centers is documented by the fact that these same 10 states reported only 62% of the nation's 1990 incident cases. Cumulative cases of AIDS (as of June 1, 1991) are also unevenly distributed throughout New England ranging from 82 cases in rural Vermont (population 571,000) to 3,855 cases in Massachusetts (population 6 million). Cumulative AIDS case rates in Massachusetts and Connecticut are nearly five times that of Vermont. (see Figure 1)

Figure 1. N. E. AIDS CASE RATES



rate based on 1990 census
Data as of 6/1/91

The spread of AIDS from urban centers is illustrated on a smaller scale in New England. Eight metropolitan areas in New England have populations of greater than 500,000 people. Four areas are in Massachusetts (Boston, Springfield, Worcester and New Bedford), three are in Connecticut (New Haven, Bridgeport and Hartford), and one is in Rhode Island (Providence). The northern New England states, Maine, New Hampshire, and Vermont do not have urban areas of that magnitude and 75% of the population live in small cities or rural areas.

An analysis of annual AIDS case rates for the period from June 1990 to June 1991 reveals that the New Haven metropolitan area had highest annual case rate in New England (20.6/100,000). Springfield's metropolitan area rate of 18.4/100,000 was the second highest rate. Both Bridgeport and Boston had the third highest AIDS case rate at 16.1/100,000. Providence's annual case rate of 8.9/100,000 was the lowest of the major metropolitan areas in New England. The remaining three areas, Worcester, New Bedford and Hartford have intermediate annual AIDS case rates. It is important to note these eight regions account for 82% of New England's cumulative AIDS cases; the city of Boston accounts for 23% of New England's cumulative cases.

Inside :

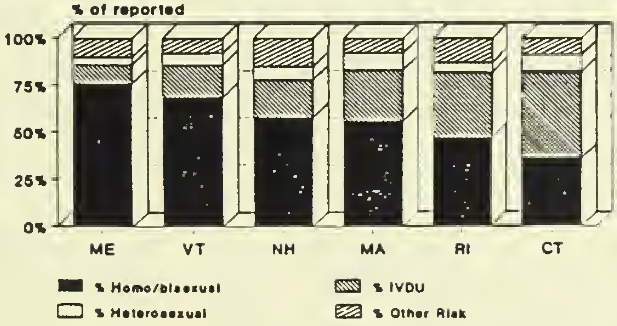
- *County Data* ..... *page 2*
- *Monthly Update* ... *page 3*
- *Calendar* .... *page 4*

Next Month :

- *Impact of Active Surveillance*

The six New England states differ not only by AIDS case numbers and rates, but also by demographic factors such as race, sex and risk behavior. In Connecticut, only 36% of the cases reported homosexual contact as a source of HIV infection; in Maine 76% of the cases reported this risk. Connecticut, the state closest to New York City, reported the highest percentage of AIDS cases in New England with a history of intravenous (IV) drug use as a risk factor (46%). In Maine, only 10% of reported AIDS cases have used intravenous drugs. (see Figure 2)

Figure 2. AIDS Cases in New England
Risk Factor by State



Data as of 6/1/91
Other risk: pediatric, hemophiliacs, transfusions & unidentified

In light of the current focus on cases among women and children, it is interesting to note the distribution of female AIDS cases in New England. Connecticut has the highest proportion of female AIDS cases in New England with 20% of their cumulative cases occurring in women. Therefore, it is not surprising that Connecticut has the fourth highest

---

* *includes the 50 states and U.S. Territories*

Table 1. Selected Demographic and Risk Factors of New England AIDS Cases

	MA	CT	RI	ME	NH	VT
AIDS cases (total)	3855	2113	417	245	211	82
%IVDU	26%	46%	35%	10%	20%	17%
% Female	12%	20%	15%	7%	10%	7%
% Pediatric (< 13 year)	2.1%	3.1%	2.4%	0.8%	2.4%	1.2%
% Non-White	34%	57%	31%	6%	10%	6%

Date from states as of 06/01/91

percentage of children among AIDS cases in the United States (3.2% of resident cases) and one of the highest newborn screening HIV seropositivity rates in the United States. Of Connecticut resident female AIDS cases, 80% report either having sex with an intravenous drug user or using IV drugs themselves. Rhode Island's data for women and children are similar to Connecticut's : 15% female cases and 2.4% pediatric cases. Data from Connecticut and Rhode Island contrast sharply with that from Maine and Vermont where 7% of the cases reported are female and approximately 1% of the AIDS cases reported are in children less than 13 years old. (see Table 1)

Communities of color comprise 22% of the United States population, yet they account for 45% of the nation's AIDS cases. A similar disproportion of AIDS cases among minorities is observed in New England. Minorities in Maine and Vermont comprise less than 2% of these state's population, yet they represent approximately 6% of AIDS cases. In New Hampshire, 10% of AIDS cases are seen in communities of color while only 3% of the state's population consists of members of these groups. The populations of Rhode Island, Massachusetts and Connecticut consist of approximately 13% minorities but report that 30%, 32%, and 57% of AIDS cases, respectively, are within communities of color. Minorities in New England continue to be disproportionately affected by the AIDS epidemic.

A look at AIDS cases over time reveals a slow-moving shift from homo/bisexual behavior to IV drug use as the predominant risk. IV drug use may be responsible for the increase in the number and percent of female, pediatric, and minority AIDS cases. From trends seen throughout the U.S., it is clear that large urban centers have witnessed these changes at an earlier point than smaller urban and rural areas. The New England region illustrates these shifts in geographic case loads and demographic makeup. Northern New England's epidemic resembles that seen in the early 1980's in cities such as San Francisco and New York City. Southern New England has many more large and medium sized urban centers where IV drug use and heterosexual contact with IV drug users will become the predominant mode of HIV transmission as has been observed in New York City, Newark, and Miami.

* * * * * * * * * * * * *

Trends in Epidemiology of AIDS in MA

* * * * * * * * * * * * *

IV Drug related AIDS cases are increasing at a faster pace than any other risk group. IV drug related cases increased from 20% of cases in 1985 to 37% of cases in 1990. Correspondingly, homo/bisexual cases decreased from 64 % of cases in 1985 to 59% cases in 1990.

MA RESIDENT CASES AND CUMULATIVE INCIDENCE RATES BY COUNTY, JUNE 30, 1991

County	Number	%MA Cases	Cases per 100,000
Berkshire	32	0.8	23
Bristol	210	5.4	42
Cape and Islands	181	4.6	89
Essex	236	6.0	35
Franklin	20	0.5	29
Hampden	252	6.5	55
Hampshire	31	0.8	21
Middlesex	617	15.8	44
Norfolk	230	5.9	37
Plymouth	176	4.5	40
Suffolk	1709	43.8	257
Worcester	210	5.4	30
TOTAL	**3904**	**100**	**65**

AIDS SURVEILLANCE SUMMARY
STATE AND NATIONAL COMPARISONS

Total Cases as of 07/01/91		Massachusetts Cases (4,192) No. (%)	United States Cases* (179,136) No. (%)
Residence			
City of Boston		1,626 (39)	
Remainder SMSA		979 (23)	
Remainder State		1,299 (31)	
Subtotal	3,904		
Out-of-State		288 (7)	
Transmission Categories (Adults)		4,097	176,047
Homosexual/Bisexual Male		2,346 (57)	103,729(59)
I. V. Drug User		907 (22)	38,987 (22)
Homosexual Male/ I.V. Drug User		166 (4)	11,611 (7)
Hemophilia		56 (1)	1,510 (<1)
Heterosexual Cases**		369 (9)	9,744 (6)
Transfusion, Blood Components		107 (3)	3,974 (2)
None of the Above		146 (4)	6,492 (4)
Transmission Categories (<13 yrs)		95	3,089
Parent with AIDS/at risk for AIDS		83 (87)	2,602 (84)
Hemophilia		4 (4)	146 (5)
Transfusion, Blood/Components		8 (8)	270 (9)
None of the Above		0 (0)	71 (2)
Sex			
Male		3,684 (88)	159,977 (89)
Female		508 (12)	19,159 (11)
Condition			
Alive		1,614 (39)	65,710 (37)
Dead		2,578 (61)	113,426 (63)
Race			
White		2,819 (67)	97,329 (55)
Black		856 (20)	51,190 (29)
Latino		481 (11)	28,831 (16)
Other/Unknown		36 (1)	1,786(<1)
Age at Initial Dx (yrs.)			
<13		95 (2)	3,089 (2)
13-19		16 (<1)	691 (<1)
20-29		854 (20)	35,635 (20)
30-39		2,052 (49)	82,231 (46)
40-49		862 (21)	39,302 (22)
50+		313 (7)	18,188 (10)

* *Total cases reported as of June 1, 1991*

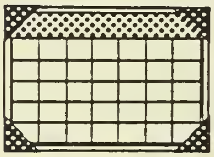
** *Includes 170 persons who have had heterosexual contact with high risk individuals and 199 persons without other identified risks who were born in countries in which heterosexual transmission is believed to play a major role.*

Update

During May, a total of ninety-eight AIDS case were reported to the Massachusetts AIDS Surveillance Program. Another fifty-three cases were reported in June.

The ***AIDS Newsletter*** will resume its regular monthly publication in August.

CALENDAR



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This 5-day entry level course is geared toward providers new to the field of HIV antibody counseling and testing. The course offers demonstrations and practice counseling sessions. For more information contact John Connors at (617)727-0368.

September 28 - October 2, 1991 Communities Making a Difference: Serving Drug-exposed and HIV-infected Children and Their Families
Sheraton Tara Hotel, Braintree. This five day institute will address community-based and family centered services for drug-exposed and HIV-infected children and their families. The course is geared towards administrators, local, state, and federal leaders and policy makers, and direct service providers and family members. Call (617)449-4500 for additional information.

To have an announcement listed in the AIDS Newsletter Calendar call (617)522-3700, extension 478.

AIDS NEWSLETTER
is a publication of the
AIDS Surveillance Program
June - July
1991

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AIDS NEWSLETTER

Vol. 7 No. 7 Monthly Publication of the Massachusetts Department of Public Health August, 1991

Impact of Active Surveillance Methods

Reliable AIDS case surveillance data enable health care, social service and public health organizations to plan for and provide appropriate services. In addition, accurate case surveillance data are crucial to our understanding of the changing AIDS epidemic and allow for an equitable division of scarce resources.

In 1982, using federal funds, New York City became the first city in the country to establish an AIDS Surveillance Program. Soon after, additional grants provided for surveillance sites in San Francisco, Los Angeles and Florida. In 1983, AIDS became a reportable disease in Massachusetts and the Massachusetts Department of Public Health (MDPH) AIDS Surveillance Program was established.

During the first years of the epidemic, the AIDS surveillance team relied predominantly on a network of Infection Control Practitioners (ICP) and specialized AIDS practitioners to report cases of the disease. By the mid-eighties, as the number of AIDS cases increased, it became apparent that although most cases were reported directly from health care facilities, many cases were being overlooked. Patient confidentiality issues, unfamiliarity with the case definition, lack of health care access for some AIDS patients and use of more than one provider by others, and reporting fatigue all have been hypothesized as reasons for underreporting.

In 1985, in an effort to illuminate reporting trends, new case methods were introduced. It was hoped that these methods would increase both the number of cases and subsequently the accuracy of AIDS data. These methods included reviews of death certificates, disease registries, medical records and hospital discharge databases. Since 1985 these active techniques have become a standard part of AIDS surveillance.

Inside:

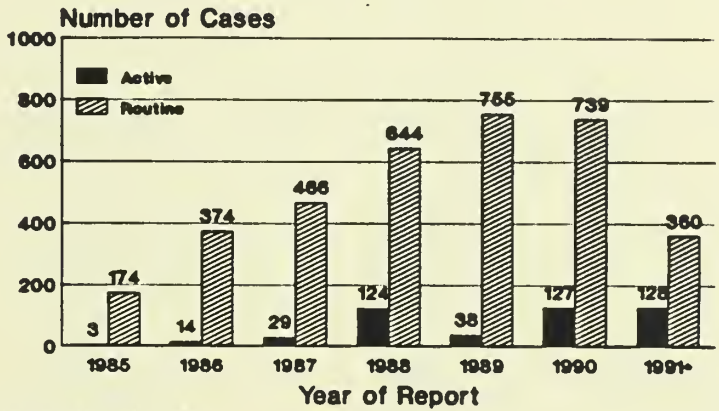
- *City and Town Case Rates...page 2*
- *Monthly Update ....page 3*
- *Calendar .... page 4*

Next Month :

- *Trends in Condom Use*

Recently, the Massachusetts AIDS Surveillance Program reviewed its various methods of case collection. As part of this study, all AIDS cases reported to the program from January 1, 1985 through May 31, 1991 were reviewed. As Figure 1 shows, the majority of cases collected since 1985 have been collected through routine surveillance methods. However, active surveillance methods have accounted for 12% of all AIDS cases reported in Massachusetts from 1985 to 1991. The percentage of active surveillance cases has ranged from a low of three cases (2%) in 1985 to a high of 128 cases (26%) for the first five months of 1991.

Figure 1.
Active and Routine Case Collection
1985-1991



*Reported as of June 1, 1991

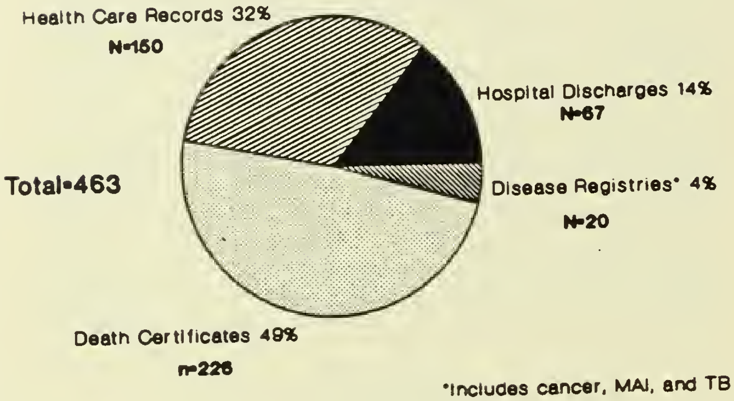
Figure 1 summarizes the proportional yield of the various active surveillance methods used. Of all the techniques used, death certificate reviews have uncovered the greatest number of AIDS cases (n = 226). Review of health care records (i.e. outpatient validation studies) have yielded 150 cases; studies which reviewed hospital discharge databases uncovered 67 cases. An analysis of demographic variables revealed that cases received by both active and routine methods were similar. No significant differences existed when compared by race, sex or mode of transmission.

An evaluation of active AIDS case collection methods is important because it allows surveillance programs to: 1. Validate the completeness of AIDS case reporting. 2. Identify pockets of unreported AIDS cases. 3. Determine whether cases reported

For case reporting of AIDS patients meeting the CDC definition, please notify AIDS Epidemiologists at (617)522-3700, ext. 482 or 478.

by active and routine surveillance methods are similar with regard to demographic variables such as risk, race and sex. 4. Establish which active surveillance methods are the most effective for case finding.

Figure 2.
Active Case Collection Methods
1985-1991



*Includes cancer, MAI, and TB

Although the majority of AIDS Cases in Massachusetts continue to be reported by health care providers directly, other cases collection methods are playing a greater role in case finding as the epidemic continues. Given the resources of AIDS surveillance programs, it is important to identify which active case finding methods are the most productive.

* * * * * * * * * * * * * * * * * * * *

Trends in AIDS Epidemiology

* * * * * * * * * * * * * * * * * * * *

The AIDS epidemic is moving beyond Boston. The percentage of cases reported among residents outside greater Boston has risen from 23% in 1985 to 39% in 1990.

Massachusetts Cities/Towns With At Least 20 AIDS Case

City/Town	Cases	Rate/100,000	City/Town	Cases	Rate/100,00
Boston	1,663	290	Malden	40	7
Springfield	171	109	Revere	36	8
Cambridge	120	125	Fall River	32	3
New Bedford	114	114	Chelsea	29	10
Worcester	108	64	Holyoke	27	6
Provincetown	101	2,836	Medford	24	4
Brockton	82	88	Everett	25	7
Somerville	79	104	Newton	23	2
Brookline	56	102	Chicopee	23	4
Lowell	51	49	Bridgewater*	22	15

*Includes MCI Cases

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AIDS SURVEILLANCE SUMMARY
STATE AND NATIONAL COMPARISONS

Total Cases as of 08/01/91		Massachusetts Cases (4,269) No. (%)	United States Cases* (182,834) No. (%)
Residence			
City of Boston		1,663 (39)	
Remainder Boston SMSA		999 (23)	
Remainder State		1,319 (31)	
Subtotal	3,981		
Out-of-State		288 (7)	
Transmission Categories (Adults)		4,172	179,694
Homosexual/Bisexual Male		2,383 (57)	105,741 (59)
I. V. Drug User		932 (22)	39,904 (22)
Homosexual Male/ I.V. Drug User		168 (4)	11,823 (7)
Hemophilia		58 (1)	1,535 (<1)
Heterosexual Contact**		378 (9)	10,011 (6)
Transfusion, Blood Components		107 (3)	4,025 (2)
None of the Above		146 (4)	6,655 (4)
Transmission Categories (<13 yrs)		97	3,140
Parent at risk for HIV Infection		85 (87)	2,645 (84)
Hemophilia		4 (4)	149 (5)
Transfusion, Blood/Components		8 (8)	271 (9)
None of the Above		0 (0)	75 (2)
Sex			
Male		3,743 (88)	163,182 (89)
Female		526 (12)	19,652 (11)
Condition			
Alive		1,645 (39)	66,850 (37)
Dead		2,624 (61)	115,984 (63)
Race/Ethnicity			
White		2,871 (67)	99,070 (55)
Black		879 (20)	52,329 (29)
Latino		483 (11)	29,586 (16)
Other/Unknown		36 (1)	1,849 (<1)
Age at Initial Diagnosis (yrs.)			
<13		97 (2)	3,140 (2)
13-19		16 (<1)	699 (<1)
20-29		871 (20)	36,266 (20)
30-39		2,095 (49)	83,956 (46)
40-49		873 (21)	40,187 (22)
50+		317 (7)	18,586 (10)

* *Total cases reported as of July 1, 1991*

** *Includes 171 persons who have had heterosexual contact with high risk individuals and 207 persons without other identified risks who were born in countries in which heterosexual transmission is believed to play a major role.*

Update

During July, a total of seventy-seven AIDS case were reported to the Massachusetts AIDS Surveillance Program.

CALENDAR

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September 30, 1991, Support Group for HIV+ Women
First night of a weekly support group for women with HIV+ who are recovering from drug and alcohol addiction. No fee required. Please contact Magda or Christine of Women, Inc. at (617) 442-6166.

October 7, 1991, 9:00 a.m., Pandemic Disease, Community Organizations, and the Future of Public Health
Auditorium, US Department of Transportation, Kendall Square, Cambridge. The MPHA will feature Jonathan Mann, MD, MPH as speaker at its annual fall meeting. For more information, please call (617) 524-6696.

October 9 and 10, 1991, Linking Hospital, Home and Community Care: Conference on Pediatric HIV Infection
This two-day meeting is intended for physicians, nurses, social workers, health educators and families affected by HIV infection. Through general sessions and group panels, conference participants will share information about services available for families affected by HIV. For more information please contact Stephanie Lodish at (617) 730-0660.

To have an announcement listed in the AIDS Newsletter Calendar, call (617) 522-3700, extension 478.

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AIDS NEWSLETTER

Vol. 7 No. 8 Monthly Publication of the Massachusetts Department of Public Health September, 1991

TRENDS IN CONDOM USE AMONG PERSONS ATTENDING TWO MDPH-FUNDED COUNSELING AND TESTING PROGRAMS

Condoms are effective in reducing the spread of Sexually Transmitted Diseases (STDs), including HIV infection. Consequently, educational efforts have been targeted at improving knowledge about condoms to increase their use in populations at risk.

Since April 1985, individuals have been able to receive free, anonymous HIV counseling and testing (C&T) at Alternate Test Sites (ATS) throughout Massachusetts. Confidential testing has been available since June 1987 at state-cooperating STD clinics. Demographic, condom use, sex partner and risk behavior information is collected on clients via a standardized interviewer-administered questionnaire during the pre-test counseling session. Information on frequency and duration of condom use has been collected since September 1988.

Self-reported condom use was evaluated for 17,775 individuals receiving C&T in these settings (11,341 ATS clients and 6,434 STD clinic patients). Condom use was categorized as "always", "sometimes" or "never". To evaluate willingness to use condoms, a variable "ever" was defined by combining those persons reporting "always" or "sometimes" using condoms. Chi-square test for trend was used to evaluate changes in condom use over the three year evaluation period and for number of sex partners.

The four main objectives of these analyses were 1) to compare patterns of condom use over time in persons seeking C&T services at ATS and STD clinics; 2) to evaluate willingness to use condoms among ATS clients and STD clinic patients who are self-identified as: homo/bisexual men (HBM), intravenous drug users (IVDU), having "multiple sex partners" (MPTR) or "low risk" (health care workers, lesbian sexual contact, anxious/curious, testing anonymously prior to a mandatory test); 3) to characterize frequency (always, sometimes, never) of condom use over time; and 4) to determine if condom use varies with the number of reported sex partners (categorized as 1, 2, 3-9 and greater than 10) in the 12 months prior to testing. The percent of persons reporting "ever" using condoms increased significantly over time for persons self-identified as HBM, MPTR, and "low risk", regardless of program. (see Graphs 1 and 2) IVDUs also increased their condom use, but the change was not statistically significant. The number of individuals reporting "ever" using condoms is increasing over time due to the rise in the number of persons reporting "sometimes" using condoms. However, as seen in the table, the percent reporting "always" using condoms is decreasing. This decrease over time was seen for most risk behavior groups.

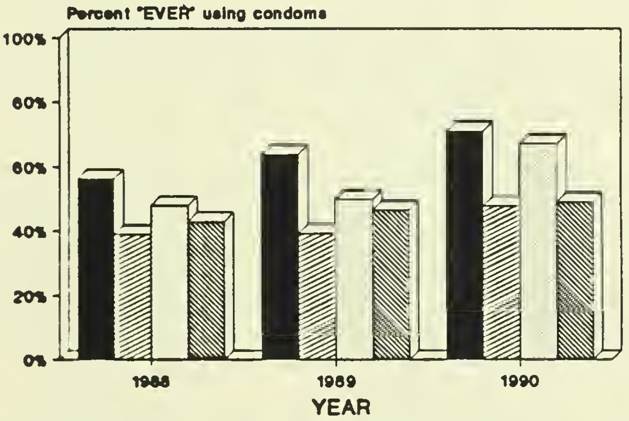
Inside:

- *U.S. AIDS Figures ...page 2*
- *Monthly Update ....page 3*
- *Calendar .... page 4*

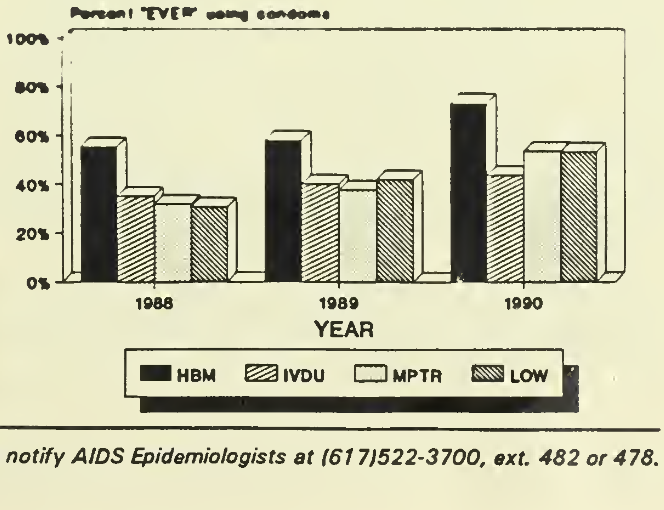
Next Month:

- *Current Trends in MA AIDS Cases*

CONDOM USE AMONG MA ATS CLIENTS



CONDOM USE AMONG MA STD PATIENTS



For case reporting of AIDS patients meeting the CDC definition, please notify AIDS Epidemiologists at (617)522-3700, ext. 482 or 478.

Table I

FREQUENCY OF CONDOM USE
"ALWAYS" BY RISK GROUP

ATS

	1988	1989	1990
HBM	47%	50%	31%
IVDU	29%	22%	19%
MPTR	37%	31%	21%
LOW	37%	31%	22%

STD

	1988	1989	1991
HBM	36%	36%	36%
IVDU	16%	14%	13%
MPTR	14%	9%	9%
LOW	12%	20%	20%

Analysis showed that condom use increased over time regardless of age or race of the client. Patterns of condom use were similar for men and women after adjusting for risk (HBM).

The number of persons reporting "ever" using condoms by the number of self-reported sex partners in the 12 months prior to HIV testing was also evaluated. The percent of persons reporting "ever using" condoms increased with the number of sex partners. This trend is statistically significant in all risk groups, except for IVDUs receiving C&T at ATS.

It is encouraging to note an increased willingness to use condoms. However, this is offset somewhat by a decrease in persons reporting that they "always" use condoms. Continued education about risk reduction must be maintained to encourage condom use. In an analysis of 1990 data by sex, race, age category and risk behavior, greater than 50% of certain sub-groups of individuals seeking C&T services reported "never" using condoms. Some examples of these sub-groups for the ATS program include: IVDUs with <10 sex partners (54%), black (40%) and Hispanic (54%) clients. Culturally appropriate educational efforts must be targeted at particular groups to increase willingness to try condoms.

The educational message about condom use is reaching groups generally considered at "lower risk" for HIV infection, as well as targeted high risk populations. Special efforts regarding changing condom use behavior need to be directed to IVDUs and other high risk groups.

* * * * * * * * * * * * * * * * * * * *

Trends in MA AIDS Epidemiology

* * * * * * * * * * * * * * * * * * * *

Massachusetts has the 10th highest number of AIDS cases, representing 2.1% of the national cases.

United States AIDS Figures

State	Number*
1. New York	39,248
2. California	35,009
3. Florida	17,332
4. Texas	13,170
5. New Jersey	11,750
6. Puerto Rico	5,819
7. Illinois	5,463
8. Pennsylvania	5,120
9. Georgia	5,034
10. Massachusetts	3,927

Metropolitan Area	
1. New York	34,090
2. Los Angeles	12,392
3. San Francisco	10,624
4. Miami	5,414
5. Washington	5,305
6. Newark	4,873
7. Chicago	4,563
8. Atlanta	3,877
9. Philadelphia	3,874
10. San Juan	2,649

**As of 8/1/91*

AIDS SURVEILLANCE SUMMARY
STATE AND NATIONAL COMPARISONS

Total Cases as of 09/01/91		Massachusetts Cases (4,353) No. (%)	United States Cases* (186,895) No. (%)
Residence at Time of Diagnosis			
City of Boston		1,682 (41)	
Remainder Boston SMSA		1,026 (25)	
Remainder State		1,356 (33)	
Subtotal	4,064		
Out-of-State		290 (7)	
Transmission Categories (Adults)		4,255	183,696
Homosexual/Bisexual Male		2,427 (57)	108,087 (59)
I. V. Drug User		954 (22)	40,774 (22)
Homosexual Male/ I.V. Drug User		174 (4)	12,089 (7)
Hemophilia		59 (1)	1,559 (<1)
Heterosexual Contact**		387 (9)	10,279 (6)
Transfusion, Blood Components		107 (3)	4,081 (2)
None of the Above		147 (3)	6,827 (4)
Transmission Categories (<13 yrs)		98	3,199
Parent at risk for HIV Infection		85 (87)	2,696 (84)
Hemophilia		4 (4)	153 (5)
Transfusion, Blood/Components		9 (9)	275 (9)
None of the Above		0 (0)	75 (2)
Sex			
Male		3,819 (88)	166,774 (89)
Female		534 (12)	20,121 (11)
Condition			
Alive		1,637 (38)	68,484 (37)
Dead		2,716 (62)	118,411 (63)
Race/Ethnicity			
White		2,935 (67)	101,219 (54)
Black		890 (20)	53,666 (29)
Latino		493 (11)	30,113 (16)
Other/Unknown		35 (1)	1,897 (<1)
Age at Initial Diagnosis (yrs.)			
<13		98 (2)	3,199 (2)
13-19		16 (<1)	715 (<1)
20-29		884 (20)	36,999 (20)
30-39		2,137 (49)	85,823 (46)
40-49		887 (20)	41,133 (22)
50+		331 (8)	19,026 (10)

* *Total cases reported as of August 1, 1991*

** *Includes 179 persons who have had heterosexual contact with high risk individuals and 208 persons without other identified risks who were born in countries in which heterosexual transmission is believed to play a major role.*

Update

During August, a total of eighty-four AIDS cases were reported to the Massachusetts AIDS Surveillance Program.

CALENDAR

September 25, 26, 27, 30 and October 1, 1991, CDC HIV Overview: Pre and Post-Test Counseling Techniques and Seropositive Issues Course
This five-day entry level course is geared toward providers new to the field of HIV antibody counseling and testing. The course offers demonstrations and practice counseling sessions. For more information contact John Connors at (617) 727-0368.

September 28 - October 2, 1991, Communities Making a Difference: Serving Drug-exposed and HIV-infected Children and Their Families
Sheraton Tara Hotel, Braintree. This five day institute will address community-based and family centered services for drug-exposed and HIV-infected children and their families. The course is geared towards administrators, local, state, and federal leaders and policy makers, and direct service providers and family members. Call (617)449-4500 for additional information.

September 30, 1991, Support Group for HIV+ Women
First night of a weekly support group for HIV+ women recovering from drug and alcohol addiction. No fee required. Please contact Magda or Christine of Women, Inc. at (617) 442-6166.

October 7, 1991, 9:00 a.m., Pandemic Disease, Community Organizations, and the Future of Public Health
Auditorium, US Department of Transportation, Kendall Square, Cambridge. The MPHA will feature Jonathan Mann, MD, MPH as speaker at its annual fall meeting. For more information, please call (617) 524-6696.

October 9 and 10, 1991, Linking Hospital, Home and Community Care: Conference on Pediatric HIV Infection
This two-day meeting is intended for physicians, nurses, social workers, health educators and families affected by HIV infection. Through general sessions and group panels, conference participants will share information about services available for families affected by HIV. For more information please contact Stephanie Lodish at (617) 730-0660.

To have an announcement listed in the AIDS Newsletter Calendar, call (617) 522-3700, extension 478.

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AIDS NEWSLETTER

Vol.7 No. ~~8~~ 9 Monthly Publication of the Massachusetts Department of Public Health October, 1991

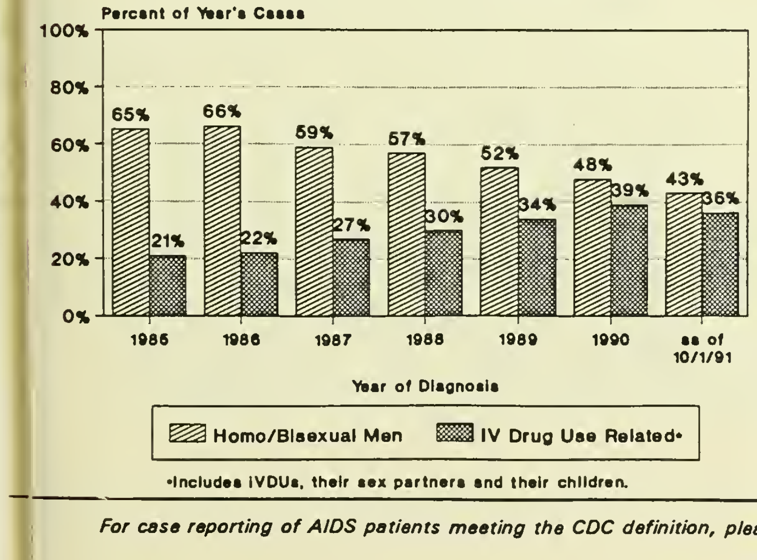
THE CHANGING FACE OF AIDS: CURRENT TRENDS IN THE EPIDEMIC IN MASSACHUSETTS

Since 1983, the AIDS Surveillance Program of the Massachusetts Department of Public Health has been collecting demographic and clinical information on CDC-defined AIDS cases diagnosed in the state. Over the past eight years, the nature of the epidemic has been gradually changing. The beginning years of the epidemic were characterized primarily by cases among gay white men in urban areas. However, in recent years the disease has been spreading out beyond metropolitan centers. Cases related to intravenous drug use (IVDU) and heterosexual contact are increasing, as are cases among communities of color, women and children. This article will summarize these changes.

•Intravenous drug related cases are increasing at a faster pace than any other risk group.

In 1985, 65% of diagnosed cases were among homo/bisexual men. By 1990, this percentage had dropped to 48%. In contrast, the number of cases among intravenous drug users, their sexual partners and infected children born to IVDU parents grew significantly during the same time period (21% to 39% of total cases). In the first eight months of 1991, IV drug use has been associated with 36% of the cases. Although the number of gay cases on average still exceeds the number of IVDU-related cases diagnosed each month, it is predicted that the proportion will reverse at some point in the future.

Massachusetts AIDS Cases: Homo/Bisexual Male vs. IV Drug Use Related



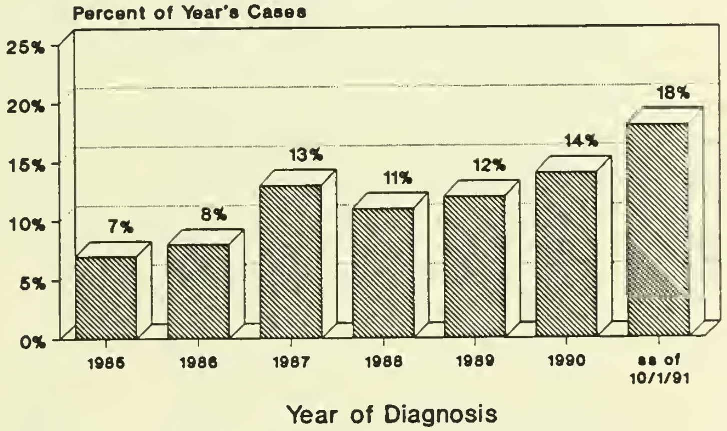
•Includes IVDUs, their sex partners and their children.

• AIDS cases among women continue to grow at a faster pace than among men.

In many geographic areas, women represent the "next wave" of the epidemic. Cases of AIDS among women rose from 7% of cases diagnosed in 1985 to 14% of cases diagnosed in 1990. In the first 8 months of 1991, women represented 18% of cases diagnosed.

Intravenous drug use plays the greatest role in HIV transmission among women. Cumulatively, 50% of the 470 adult female cases in Massachusetts have acquired their infection through IV drug use. An additional 20% of women acquired HIV through sexual contact with an IV drug user. In total, IV drug use is directly or indirectly responsible for 70% of adult female AIDS cases. Over time, the proportion of women with AIDS due to IV drug use has been increasing from 47% of 1985 cases to 74% of 1990 cases.

Trends in AIDS Cases Among Massachusetts Women



Inside:
- Monthly Update....page 3
- Calendar..........page 4

Next Month:
- MDPH WAR Project

- **Heterosexually acquired AIDS cases are growing at the same pace as the rest of the epidemic, and have consistently represented about 9% of the total number of cases each year.**

Of the 373 heterosexual cases diagnosed in Massachusetts, 204 (55%) are people born in African or Caribbean countries (where heterosexual contact is the predominent mode of transmission), 126 (34%) are sexual partners of IV drug users, and 43 (11%) are sexual partners of other high risk individuals: hemophiliacs, blood transfusion recipients, and other people with documented HIV infection or AIDS. Over the past decade, the proportion of heterosexually acquired AIDS cases has remained steady at about 8-9% of the year's diagnosed cases. However, the data for the first eight months of 1991 indicate an increase in the number of heterosexual cases. Fifteen percent of 1991 cases report heterosexual transmission. However, these data are still incomplete due to reporting delay. It is yet to be determined whether this is a true increase or an artifact of reporting delay.

- **AIDS is disproportionately represented among communities of color.**

While only 10% of the general adult population in Massachusetts is non-white, 29% of adult male cases, 59% of adult female cases, and 73% of pediatric cases are among communities of color.

1990 incidence rates show that black men were diagnosed with AIDS at a rate six times that of white men, while latino men were diagnosed at a rate four times that of white men. Among women, the racial discrepancies are even larger. The 1990 case rate for black women was 22 times as high as white women; for latino women it was 17 times as high.

Annual Incidence Rates for MA Residents by Race/Ethnicity and Gender

		White	Black	Latino
Male	1985	7.0	51.7	27.6
	1990	24.2	142.0	106.2
Female	1985	0.3	5.6	4.3
	1990	1.8	40.4	31.4

Cases per 100,000 population.

- **Among pediatric cases, parental IV drug use is the predominent risk factor.**

Of 88 pediatric cases cumulatively reported to the AIDS Surveillance Program as of September 1, 1991, 88% are children born to HIV infected women. Of these children, over half were born to women who used drugs themselves or who had sex with an IV drug user. One third of these pediatric cases have been diagnosed since 1990.

- **AIDS is being diagnosed increasingly on an outpatient basis.**

Education, familiarity with the clinical spectrum of HIV disease, and shifts in resources have enabled providers to diagnose certain AIDS indicator diseases in outpatient settings. Increased outreach by surveillance staff to community health centers, HMO's, and private physician offices have insured a continued high rate of reporting completeness. In 1985, 4% of cases were diagnosed as outpatients. In 1990, this percentage increased to 19%. During the first eight months of 1991, 30% of cases have been diagnosed at outpatient facilities.

- **The AIDS epidemic is moving beyond large metropolitan centers.**

Although AIDS is still centered in large urban areas, there has been a gradual but steady shift away from these areas. In 1985, 56% of cases were residents of the four largest cities in the Commonwealth: Boston, Lowell, Springfield, and Worcester. By 1990, this number had fallen to 48%, and for the first eight months of 1991, only 41% of diagnosed cases are residents of these four cities. While growth in the epidemic is still occurring rapidly in cities such as New Bedford and Brockton, HIV is moving out beyond city borders. Already 74% of the 351 cities and towns in Massachusetts have reported at least one AIDS case.

The nature of the AIDS epidemic in Massachusetts is changing over time as it has in many other parts of the United States. Increasingly more cases of AIDS are associated with intravenous drug use. More women and children, particularly those from communities of color are being affected by the spectrum of HIV disease.

AIDS surveillance activities continue to be important as they allow us to describe the epidemic and its changes over time. This information in turn can be used to target prevention and treatment services and can help us to plan for the health care needs of HIV infected individuals.

For case reporting of AIDS patients meeting the CDC definition, please notify AIDS Epidemiologists at (617)522-3700, ext. 482 or 478.

MA AIDS SURVEILLANCE SUMMARY

	Boston		Massachusetts		United States*	
Total Cases reported as of 10/1/91	1,702		4,404		191,601	
	No.	%	No.	%		
Residence						
City of Boston	1,702		1,702	39%		
Remainder of Boston SMSA**			1,036	24%		
Remainder of Massachusetts			1,375	31%		
Subtotal	1,702		4,113	93%		
Out-Of-State			291	7%		
Transmission Mode (Adult)	1,672		4,306		188,348	
Homosexual/Bisexual Male	1,022	61%	2,447	57%	110,678	59%
I.V. Drug User	321	19%	974	23%	41,963	22%
Homosexual I.V. Drug User	61	4%	175	4%	12,334	7%
Hemophiliac	7	0%	59	1%	1,597	1%
Heterosexual***	184	11%	392	9%	10,636	6%
Blood Transfusion Recipients	18	1%	107	2%	4,147	2%
Undetermined	59	4%	152	4%	6,993	4%
Transmission Mode (Pediatric)	30		98		3,253	
Mother with AIDS/at risk for HIV	28	93%	85	87%	2,738	84%
Hemophiliac	0	0%	4	4%	156	5%
Blood Transfusion Recipient	2	7%	9	9%	281	9%
Undetermined	0	0%	0	0%	78	2%
Gender						
Male	1,507	89%	3,860	88%	170,823	89%
Female	195	11%	544	12%	20,778	11%
Mortality Status						
Alive	608	36%	1,635	37%	68,686	36%
Dead	1,094	64%	2,769	63%	122,915	64%
Race/Ethnicity						
White	996	59%	2,967	67%	103,502	54%
Black	562	33%	903	21%	55,181	29%
Hispanic	133	8%	499	11%	30,964	16%
Other/Unknown	11	1%	35	1%	1,954	1%
Age Group (years)						
Under 13	30	2%	98	2%	3,253	2%
13 - 19	1	0%	16	0%	737	0%
20 -29	327	19%	896	20%	37,808	20%
30 - 39	899	53%	2,162	49%	87,973	46%
40 - 49	342	20%	898	20%	42,303	22%
Over 49	103	6%	334	8%	19,527	10%

* Total Cases reported as of September 1, 1991

** Refers to the Boston Standard Metropolitan Statistical Area

*** Includes 180 persons who have had heterosexual contact with high risk individuals and 212 persons without other identified risks who were born in countries in which heterosexual contact is believed to play a major role.

UPDATE:

In September, fifty-one AIDS cases were reported to the Massachusetts AIDS Surveillance Program.

CALENDAR

November 16 and 17, 1991, Harvard Community Health Plan Symposium on HIV in the 90's, Management in the Primary Care Setting
Brandeis University, Waltham. This symposium will explore some of the epidemiological, clinical and social aspects of the HIV epidemic. CEU's and CME's are available. Registration costs are $110 for physicians and $75 for allied health care professionals. For registration and information please call Mary Blumenthal at (617) 421-6002.

November 20, 1991, 8:30 - 5:30, AIDS HIV and the Dental Profession,
Natick Inn, Natick. Sponsored by the Massachusetts Department of Public Health, HIV/AIDS Bureau and the AIDS Action Committee of Boston. The cost of the seminar is $75 which includes lunch and refreshments. To register, please call Wayne Kaufman before November 11 at (617) 437-6200 X314.

To have an announcement listed in the AIDS Newsletter Calendar, call (617) 522-3700, extension 478.

AIDS NEWSLETTER
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AIDS NEWSLETTER

Vol.7 No. 10 Monthly Publication of the Massachusetts Department of Public Health November, 1991

WAR: WOMEN'S AWARENESS RESOURCES PROJECT

Women working as prostitutes are at very high risk of HIV infection. A variety of factors contribute to the alarmingly high seroprevalence rates; the most obvious being their number of sex partners. A less obvious, but perhaps more important factor, is injection drug use. Women working the streets are more likely to be injection drug users and/or have partners who are past or present injection drug users than prostitutes working in other settings. Nationwide HIV seroprevalence studies have shown a correlation between injection drug use and seropositivity among prostitutes. In addition, lack of access to health care and social services leaves these women particularly vulnerable.

In an attempt to address the needs of this high risk population, an innovative program, the Women's Awareness Resource Project (WAR), was developed by a partnership of Women Inc., (a community based drug treatment facility), the Centers for Disease Control, and the Massachusetts Department of Public Health (MDPH). The WAR Project is an AIDS prevention and outreach project designed to provide education and anonymous counseling and testing to women working as prostitutes in Boston.

The primary goal of the WAR project is to decrease the transmission of HIV infection both to and from sex workers. To achieve this, the WAR Project staff educate sex workers about HIV infection in order to promote behavioral change to reduce risk. In addition, the provision of accessible counseling and testing may assist in linking HIV positive women to needed health care services and drug treatment sites. The team uses a gradual, non-intimidating approach which seeks first to become visible to prostitutes, then to establish preliminary contact with them and finally to explain the project's purpose.

All members of the WAR project team have extensive knowledge of addictive behavior and the sex industry, and have experience working with communities of color. The staff are trained to work with HIV and AIDS related problems in culturally diverse communities. The centerpiece of the program is the mobile WAR unit, a van which brings counseling and testing to the areas of Boston most frequented by sex workers. These areas include Bay Village, Chinatown, the Fenway, Blue Hill Avenue, and Washington Street. The outreach team maintains a regularly scheduled route so that prostitutes will become familiar with the operating hours. These are generally weekday and weekend evenings, often as late as 2:00 AM. A fixed site is also maintained in Roxbury for women who choose to visit during daytime hours.

The WAR project staff receive specialized training from the MDPH staff in counseling and testing, phlebotomy, and fingerstick procedures. A technique developed at the Massachusetts State Laboratory Institute makes use of paper-absorbed fingerstick blood samples for HIV antibody testing. The WAR project staff dispense condoms, spermicide, and bleach to reduce the spread of HIV. Space is available in the van to conduct private counseling sessions. Women with positive test results are referred for case management services to Women, Inc..

In addition to providing services, the WAR team conducts interviews in order to collect demographic information on the women they serve. Of the more than 100 women surveyed, roughly half were between the ages of 20 and 29. The average participant had two children. Five percent of the women were pregnant at the time. About one half had no high school degree, one third had completed high school and about one fifth had completed some college or vocational training. Ninety-five percent had no other form of employment. Condom use among sex workers is reportedly higher with clients than with sexual partners in their private lives.

The mobile service unit and WAR Project resources enable these women to seek help during their working hours and provide them with the opportunity to access health and referral services on their own terms. Underscoring this was a thank you note received from a sex worker commending them for their commitment to providing essential and non-judgmental services to an unacknowledged and under-served population.

Inside:

- AIDS by Institution..page 2
- Monthly Update....page 3
- Calendar..........page 4

Next Month:

- Pediatric Update

For case reporting of AIDS patients meeting the CDC definition, please notify AIDS Epidemiologists at (617)522-3700, ext. 482 or 478.

AIDS CASES ACCORDING TO INSTITUTE OF DIAGNOSIS

Massachusetts Department of Public Health

November 1, 1991

Institute of Diagnosis*	Cumulative Total		9/1/90 – 9/1/91	
	No.	%	No.	%
AtlantiCare	24	0.5%	13	1.1%
Baystate Medical Center	179	4.0%	71	6.2%
Berkshire Medical Center	34	0.8%	13	1.1%
Beth Israel Hospital	301	6.7%	46	4.0%
Boston City Hospital	436	9.7%	121	10.5%
Brigham & Women's Hospital	284	6.3%	72	6.3%
Brockton Hospital	30	0.7%	12	1.0%
Cambridge City Hospital	48	1.1%	22	1.9%
Cape Cod Community Hospital	30	0.7%	4	0.3%
Carney Hospital	57	1.3%	13	1.1%
Charlton Memorial Hospital	28	0.6%	9	0.8%
Children's Hospital	59	1.3%	15	1.3%
Faulkner Hospital	29	0.6%	3	0.3%
Fenway Community Health Center	192	4.3%	54	4.7%
Framingham Union Hospital	21	0.5%	5	0.4%
Harvard Community Health Plan	140	3.1%	27	2.4%
Lahey Clinic	56	1.2%	6	0.5%
Lawrence General Hospital	27	0.6%	11	1.0%
Lemuel Shattuck Hosptial	138	3.1%	49	4.3%
Massachusetts General Hosptial	404	8.9%	61	5.3%
Mercy Hospital	42	0.9%	14	1.2%
Mt. Auburn Hospital	84	1.9%	12	1.0%
New England Deaconess Hospital	517	11.5%	72	6.3%
New England Medical Center	177	3.9%	34	3.0%
Newton–Wellesley Hospital	27	0.6%	9	0.8%
St. Elizabeth's Hospital	67	1.5%	13	1.1%
St. Luke's Hospital	82	1.8%	26	2.3%
University Hospital	63	1.4%	9	0.8%
Univ. of Mass. Medical Center	129	2.9%	48	4.2%
V.A. Medical Centers	102	2.3%	31	2.7%
Worcester Memorial Hospital	43	1.0%	14	1.2%
Other Boston Hospitals	78	1.7%	37	3.2%
Other non–Boston Hospitals**	586	13.0%	201	17.5%
	4514		1147	

Total as of:
October 1, 1992: 4,404
May 1, 1991: 4,041

**Institutions with 20 or more cumulative cases*

***Includes 102 Massachusetts residents diagnosed out-of-state*

For case reporting of AIDS patients meeting the CDC definition, please notify AIDS Epidemiologists at (617)522-3700, ext. 482 or 478.

AIDS SURVEILLANCE SUMMARY

	Boston		Massachusetts		United States*	
Total Cases reported as of 11/1/91	1,744		4,514		195,718	
	No.	%	No.	%		
Residence						
City of Boston	1,744		1,744	39%		
Remainder of Boston SMSA**			1,071	24%		
Remainder of Massachusetts			1,405	31%		
Subtotal	1,744		4,220	93%		
Out-Of-State			294	7%		
Transmission Mode (Adult)	1,713		4,306		192,406	
Homosexual/Bisexual Male	1,053	61%	2,506	58%	112,812	59%
I.V. Drug User	327	19%	1,002	23%	43,028	22%
Homosexual I.V. Drug User	62	4%	178	4%	12,580	7%
Hemophiliac	7	0%	59	1%	1,622	1%
Heterosexual***	187	11%	404	9%	10,989	6%
Blood Transfusion Recipients	18	1%	108	3%	4,205	2%
Undetermined	59	3%	157	4%	7,170	4%
Transmission Mode (Pediatric)	31		100		3,312	
Mother with AIDS/at risk for HIV	29	94%	87	87%	2,785	84%
Hemophiliac	0	0%	4	4%	160	5%
Blood Transfusion Recipient	2	6%	9	9%	284	9%
Undetermined	0	0%	0	0%	83	3%
Gender						
Male	1,544	89%	3,954	88%	174,398	89%
Female	200	11%	560	12%	21,320	11%
Mortality Status						
Alive	631	36%	1,685	37%	65,442	33%
Dead	1,113	64%	2,829	63%	126,159	64%
Race/Ethnicity						
White	1,029	59%	3,046	67%	105,418	54%
Black	569	33%	922	20%	56,447	29%
Hispanic	135	8%	510	11%	31,876	16%
Other/Unknown	11	1%	36	1%	1,977	1%
Age Group (years)						
Under 13	31	2%	100	2%	3,312	2%
13 - 19	1	0%	16	0%	751	0%
20 -29	330	19%	909	20%	38,526	20%
30 - 39	923	53%	2,226	49%	89,830	46%
40 - 49	353	20%	919	20%	43,332	22%
Over 49	106	6%	344	8%	19,967	10%

* Total Cases reported as of October 1, 1991

** Refers to the Boston Standard Metropolitan Statistical Area

*** Includes 189 persons who have had heterosexual contact with high risk individuals and 215 persons without other identified risks who were born in countries in which heterosexual contact is believed to play a major role.

UPDATE:

In October, one hundred and thirteen AIDS cases were reported to the AIDS Surveillance Program.

CALENDAR

Wednesday, December 4, 1991, Adolescent Networking Meeting
9:00 A.M. - 10:00 A.M. Medical Foundation Prevention Center, 95 Berkeley Street, Boston. Dorothy Webber will speak about HIV and emotionally disturbed, learning disabled adolescents. For further more information call (617) 727-0368.

Tuesday, December 10, 1991, HIV Educational Series
9:30 A.M. - 4:00 P.M., Centro Las Americas, 11 Sycamore Street, Worcester, MA. Addressing Oppression: A participatory workshop to provide new ways of examining the roots of oppression as it affects work in HIV/AIDS. For more information please call Christie Burke at (617) 727-0368.

Ongoing:

Every Monday, Support Group for HIV+ Women
Weekly support group for HIV+ women recovering from drug and alcohol addiction. No fee required. Please contact Magda or Christine of Women, Inc. at (617) 442-6166.

To have an announcement listed in the AIDS Newsletter Calendar, call (617) 522-3700, extension 478 or 482.

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AIDS NEWSLETTER

Vol. ~~8~~ 7 No. 11 Monthly Publication of the Massachusetts Department of Public Health December, 1991

HIV/AIDS in Massachusetts Children

As of December 1 of this year, 101 cumulative cases of AIDS in children under the age of 13 have been reported to the Massachusetts AIDS Surveillance Program. The Massachusetts percentage of pediatric AIDS cases (2%) is comparable to the national percentage.

The current surveillance definition for pediatric AIDS does not accurately reflect the extent of pediatric HIV-related morbidity and mortality. In order to estimate the total number of HIV-infected children in Massachusetts and to systematically review the clinical manifestations of pediatric HIV disease, the Massachusetts Department of Public Health initiated the "Pediatric Spectrum of Disease" (PSD) project in 1989.

Funded by the Center for Disease Control (CDC), the PSD project is currently in its third year of data collection from study sites across the state. The six hospitals involved collectively report more than 95% of all pediatric AIDS cases. In addition to these hospital sites, a research nurse with the Department of Social Services (DSS) participates in the PSD project, providing the required clinical and demographic data on children who have been enrolled by the nurses at the hospital study sites. A total of 491 children of HIV-infected mothers have been enrolled in the PSD study as of December 1, 1991.

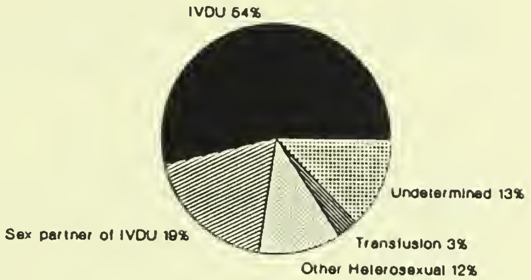
Pediatric HIV Classification

- *PO (indeterminate)* *n = 95*
- *P1 (asymptomatic)* *n = 19*
- *P2 (symptomatic)* *n = 205*
- *P3 (seroreverter)* *n = 172*

Of the 205 P2's, 100 meet the current AIDS case definition. The major AIDS-defining illnesses reported for these children include 46 cases with Pneumocystis carinii pneumonia (PCP), 30 cases with Lymphoid interstitial pneumonia (LIP), 25 cases with recurrent bacterial infections, and 19 cases with HIV encephalopathy.

A total of 97% of the children enrolled in the PSD study were born to mothers with HIV infection while 3% acquired their infection through transfusions or receipt of blood components. Of the 477 potential perinatal cases, 346 (73%) have a maternal risk of IV drug use or sexual contact with an IV drug user.

Mother's Risk
Enrolled Cases (477)



As with Adult AIDS cases, children of color bear a disproportionate burden of HIV infection. The racial distribution of PSD cases is 40% Black, 29% Hispanic, 25% White and 7% unknown. Approximately 60% of the children enrolled in PSD are currently living with a biological parent and another 27% are in foster care. Medicaid provides reimbursement for 79% of the children. Only 2% of the enrolled children have no insurance coverage noted in their records. The Department of Social Services is currently involved with 48% of the PSD children.

Based on the data, the children enrolled in the PSD study were at increased risk for adverse perinatal experiences. Approximately 21% were low birthweight (<2500 grams) and 14% were premature. Thirty percent of the children (148) spent more than a week in the nursery before being discharged, and of these children, 28% stayed longer than a month after their birth. These adverse affects do not appear to be HIV related but rather related to the mother's IV drug use as evidenced by the fact that approximately 24% of the children had drug withdrawal symptoms at birth.

Inside:

• Massachusetts County Update...........page 2
• Monthly Update........................page 3
• Calendar...............................page 4

Next Month:
• Seroprevalence Update

For case reporting of AIDS patients meeting the CDC definition, please notify AIDS Epidemiologists at (617)522-3700, ext. 482 or 478.

CONCLUSIONS

- Data from the PSD study shows that the main risk factors for pediatric HIV infection are maternal IV-drug use or maternal sex partner's IV-drug use.
- Children of color are at disproportionately greater risk for HIV infection.
- The major diseases reported for children with AIDS include illnesses that have potential prophylactic treatments, such as PCP and recurrent bacterial infections.

The PSD study provides an estimate of the prevalence of pediatric HIV infection in Massachusetts and permits a better description of the spectrum of disease in children. In addition, this study will determine the proportion of infected children who meet the AIDS case definition and how well that definition measures pediatric HIV-related disease in the community. By characterizing demographic features of infected children and the clinical manifestations of HIV infection, the PSD study will be helpful in guiding resource allocation to better serve children at risk.

MASSACHUSETTS RESIDENT AIDS CASES & RATES BY COUNTY

totals as of December 1, 1991

County	MA Cases No.	MA Cases %	Cumulative Cases per 100,000*	Alive Cases No.	Alive Cases %
Barnstable	184	4.3%	98.6	54	3.5%
Berkshire	36	0.8%	25.8	16	1.0%
Bristol	225	5.3%	44.4	95	6.2%
Essex	267	6.2%	39.8	85	5.5%
Franklin	20	0.5%	28.5	9	0.6%
Hampden	269	6.3%	59.0	88	5.7%
Hampshire	38	0.9%	25.9	18	1.2%
Islands	13	0.3%	73.7	4	0.3%
Middlesex	687	16.0%	49.1	267	17.4%
Norfolk	264	6.2%	42.9	99	6.4%
Plymouth	194	4.5%	44.6	74	4.8%
Suffolk	1855	43.3%	279.4	648	42.2%
Worcester	233	5.4%	32.8	80	5.2%
TOTAL	4285	100%	71.2	1537	

* Based on 1990 Census

AIDS SURVEILLANCE SUMMARY

	Boston		Massachusetts		United States*	
Total Cases reported as of 12/1/91	1,764		4,580		199,406	
	No.	%	No.	%		
Residence						
City of Boston	1,764		1,764	39%		
Remainder of Boston SMSA**			1,092	24%		
Remainder of Massachusetts			1,429	31%		
Subtotal	1,764		4,285	94%		
Out-Of-State			295	6%		
Transmission Mode (Adult)	1,733		4,479		196,034	
Homosexual/Bisexual Male	1,065	61%	2,538	57%	114,749	59%
I.V. Drug User	330	19%	1,021	23%	43,964	22%
Homosexual I.V. Drug User	62	4%	182	4%	12,761	7%
Hemophiliac	7	0%	60	1%	1,655	1%
Heterosexual	190	11%	411	9%	11,330	6%
Blood Transfusion Recipients	18	1%	108	2%	4,253	2%
Undetermined	61	4%	159	4%	7,322	4%
Transmission Mode (Pediatric)	31		101		3,372	
Mother with AIDS/at risk for HIV	29	94%	88	87%	2,839	84%
Hemophiliac	0	0%	4	4%	164	5%
Blood Transfusion Recipient	2	6%	9	9%	285	8%
Undetermined	0	0%	0	0%	84	2%
Gender						
Male	1,560	88%	4,010	88%	177,548	89%
Female	204	12%	570	12%	21,858	11%
Mortality Status						
Alive	641	36%	1,707	37%	71,117	36%
Dead	1,123	64%	2,873	63%	128,289	64%
Race/Ethnicity						
White	1,039	59%	3,089	67%	107,129	54%
Black	578	33%	937	20%	57,671	29%
Hispanic	135	8%	517	11%	32,579	16%
Other/Unknown	12	1%	37	1%	2,027	1%
Age Group (years)						
Under 13	31	2%	101	2%	3,372	2%
13 - 19	1	0%	16	0%	758	0%
20 -29	333	19%	921	20%	39,177	20%
30 - 39	935	53%	2,256	49%	91,515	46%
40 - 49	357	20%	937	20%	44,228	22%
Over 49	108	6%	349	8%	20,356	10%

* Total Cases reported as of November 1, 1991

** Refers to the Boston Standard Metropolitan Statistical Area

UPDATE:

In November, sixty-seven AIDS cases were reported to the AIDS Surveillance Program.

CALENDAR

"Treating HIV Clients: Identifing and responding to Social Worker's Stresses."
Thursday, February 20, 1992, National Association of Social Workers, Audrey Kennedy Building New England Deaconess Hospital, 8:00 a.m. - 4:30 p.m. Sliding registration fee, for further information call (617) 227-9635.

Ongoing:

Every Monday, Support Group for HIV+ Women
Weekly support group for HIV+ women recovering from drug and alcohol addiction. No fee required. Please contact Magda or Christine of Women, Inc. at (617) 442-6166.

Job Announcement:

Creole speaking RN to teach Haitian people to become certified home-health Aides caring for Haitian PWA's. Must be Massachusetts licensed and bilingual English-Creole. For more information please call Ken Trask, Cambridge Visiting Nurse Association at (617) 547-2620.

To have an announcement listed in the AIDS Newsletter Calendar, call (617) 522-3700, extension 478 or 482.

AIDS NEWSLETTER
is a publication of the
AIDS Surveillance Program

December
1991

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AIDS NEWSLETTER

Vol. ~~10~~ 8 No. 1 Monthly Publication of the Massachusetts Department of Public Health January, 1992

A Review of CDC HIV Seroprevalence Surveys in Massachusetts (Part I)

The Federal Centers for Disease Control instituted a sentinel serosurveillance system for HIV infection in October 1987. These Seroprevalence Surveys were initiated in the Boston metropolitan area in 1988 through a cooperative effort between the Massachusetts Department of Public Health (MDPH) and the Boston Department of Health and Hospitals (BDHH). The objectives of the serosurveys are threefold: 1) to provide state and local health advisors with data on HIV infection to assist in establishing, targeting, and evaluating education and prevention activities, 2) to indicate changes over time in the prevalence of HIV infection in selected populations, and 3) to help project the number of persons who will require medical care due to HIV infection.

Clinic based serosurveys currently in progress in Massachusetts are listed in Table 1. MDPH also conducts a population based survey of childbearing women which is funded by the National Institute of Child Health and Human Development. Data from these studies will be presented in this and next month's AIDS newsletter. Data from additional population based studies (Job Corps recruits, blood donors, military applicants) are available but will not be presented in this series.

Clinic based seroprevalence surveys are performed at specific sites based on AIDS case incidence rates, location, demographic composition of the clinic's clientele, and willingness and ability to collect the necessary information. Blinded or "unlinked" surveys utilize "leftover" serum collected for routine diagnostic tests. Demographic and in some cases risk information are retained for each specimen, but all personal identifiers are removed before the specimen is tested for HIV-1 antibody. The amount and type of information available from these surveys is limited, but the information is less biased by self selection. Surveys of Risk Behavior or "linked" surveys are conducted as adjuncts to voluntary counseling and testing programs. Participants in these surveys agree to complete a detailed behavioral questionnaire and they receive counseling and testing for HIV infection, but as in the unlinked studies, personal identifiers are removed prior to testing. The following data cover the period from July 1990 through June 1991 (FY 91).

Inside:

- **Monthly Update............page 3**
- **Calendar..................page 4**

Next Month:

- **A Review of CDC HIV Seroprevalence Surveys (Part II)**

Table 1.
Current HIV Seroprevalence Surveys in Massachusetts

Year*	Survey Type	Clinic Type (# of sites)
1988	Unlinked	TB (3)
	Unlinked	STD (7)
	Unlinked	Drug Treatment (4)
	Unlinked	Women's Health (3)
1990	Linked	TB (1)
	Linked	Drug Treatment (2)
	Linked	Woman's Health (3)
	Unlinked	Prison/Jail (5)

*Year Begun

Although each type of survey is limited in its scope, together these surveys provide information that describes the changing HIV epidemic. Since it may take up to ten or more years for a person to develop AIDS after he or she is infected with HIV, data from seroprevalence studies can be used to project future AIDS cases.

Childbearing Women- In this blinded survey, blood from newborn infants is tested and used as a surrogate for the mother's HIV serostatus. Observed rates of

For case reporting of AIDS patients meeting the CDC definition, please notify AIDS Epidemiologists at (617)522-3700, ext. 482 or 478.

HIV seroprevalence in childbearing women vary by geographic region of the state, from a high of approximately 1.0% in inner-city Boston to a low of 0.1% in more rural and suburban areas. HIV seropositivity statewide in FY 91 was 0.25% of 91,000 specimens tested. Of all the surveys administered by the MDPH, this survey is perhaps the most indicative of seroprevalence in the general population of sexually active women.

Sexually Transmitted Disease (STD) Clinics- Unlinked surveys in STD Clinics were conducted by MDPH in six clinics throughout the state during FY 91. Of 6655 specimens tested during that time 200 were positive for HIV (3.0%), with a range among clinics of 1.7% to 4.2%. Men had a higher rate of infection than women (3.2% vs. 2.7%). Persons in the 30 - 34 year age category exhibited the highest seroprevalence; 5.7% were seropositive (Table 2). Non-whites had higher rates of infection than whites. Seroprevalence rates were 2.4%, 3.3%, and 4.1% among whites, blacks and hispanics respectively. The highest rates of seropositivity were seen in persons who reported that they are sexual partners of HIV positive persons (28.6%), gay/bisexual males (23.0%), or injecting drug users (IDU) (17.5%). Among the 4244 persons who stated that their main risk for HIV infection was heterosexual sex with more than one partner in the last year, 2.0% were found to be positive; a rate approximately 8 times greater than that of the "general population" of sexually active women cited earlier.

Correctional Facilities - HIV serosurveys are currently in place at three state prisons, two for men and one for women, and two jails, one for men and one for women. The survey in the jail for men is administered by BDHH; the other surveys are administered by MDPH. In general, a prison is run by the state, and prisoners housed there have been convicted of felonies. Jails are run by the county and hold persons convicted of misdemeanors, or person who have not yet been sentenced. Data from HIV testing at the women's jail is limited since this survey was only started in May 1991 and will be excluded from the following discussion.

Of 4319 sera tested from the participating correctional institutions, 347 (8.0%) were positive for HIV antibody. The observed rate of seropositivity in each of the correctional institutions ranged from 6.4 to 12.5%. The most frequently reported risk among seropositives was current or past injection drug use. Seroprevalence rates and patterns among men in prison and men in jail were similar; therefore, prison and jail data were combined.

In contrast to the pattern observed at STD clinics, incarcerated women had higher rates of seroprevalence than men who were incarcerated (12.5% vs. 7.5%). This is most likely due to the fact that of those women, 28.3% reported a history of current or past injecting drug use, while among men only 14.9% reported this risk. The pattern of seroprevalence by age category among inmates is similar to that observed in STD clinics, although the rate for each age strata is approximately two times as high in the incarcerated population (see Table 2.).

Table 2.
HIV Seroprevalence of Two Survey Populations

Age Years	STD Survey*	Prison Survey*
15-19	0.7	0.6
20-24	1.6	3.2
25-29	4.2	8.7
30-34	5.7	13.0
35-39	3.9	12.6
40-44	4.1	10.0
45+	2.2	4.2

***% positive**

As in STD clinics, non-whites in correctional facilities had a higher rate of HIV infection than whites. While 5.9% of incarcerated whites were HIV seropositive, 7.4% of blacks and 14.0% of hispanics were seropositive. The highest rates of seropositivity were observed among persons stating that they were sex partners of HIV positive persons (35.4%), gay/bisexual men (25.0%), or IDU's (23.6%). Among persons reporting that their major risk for HIV infection was heterosexual sex with more than one person in the last year, seroprevalence was 3.7%. Seroprevalence varied inversely with duration of sentence; 9.9% of those serving less than three years were seropositive compared to 5.7% of those serving longer sentences. Data from these surveys in the prison system are used in HIV educational programs to encourage inmates to seek available counseling and testing services. Additionally, the data are used to evaluate the progress of the counseling and testing programs, and to project prison system HIV care costs.

For more information about the HIV seroprevalence surveys, please call Julia Salter at 522-3700 x191. National data through 1990 are available by calling the National AIDS Information Clearinghouse at (800) 458-5231.

Next Month: A Review of CDC HIV Seroprevalence Surveys in Massachusetts (Part II)

AIDS SURVEILLANCE SUMMARY

	Boston		Massachusetts		United States*	
Total Cases reported as of 1/1/92	1,782		4,634		199,406	
	No.	%	No.	%		
Residence						
City of Boston	1,782		1,782	38%		
Remainder of Boston SMSA**			1,102	24%		
Remainder of Massachusetts			1,453	31%		
Subtotal	1,782		4,337	94%		
Out-Of-State			297	6%		
Transmission Mode (Adult)	1,751		4,479		196,034	
Homosexual/Bisexual Male	1,077	62%	2,563	57%	114,749	59%
I.V. Drug User	332	19%	1,035	23%	43,964	22%
Homosexual I.V. Drug User	62	4%	184	4%	12,761	7%
Hemophiliac	7	0%	60	1%	1,655	1%
Heterosexual	193	11%	417	9%	11,330	6%
Blood Transfusion Recipients	18	1%	109	2%	4,253	2%
Undetermined	62	4%	165	4%	7,322	4%
Transmission Mode (Pediatric)	31		101		3,372	
Mother with AIDS/at risk for HIV	29	94%	88	87%	2,839	84%
Hemophiliac	0	0%	4	4%	164	5%
Blood Transfusion Recipient	2	6%	9	9%	285	8%
Undetermined	0	0%	0	0%	84	2%
Gender						
Male	1,576	88%	4,054	87%	177,548	89%
Female	206	12%	580	13%	21,858	11%
Mortality Status						
Alive	650	36%	1,732	37%	71,117	36%
Dead	1,132	64%	2,902	63%	128,289	64%
Race/Ethnicity						
White	1,051	59%	3,121	67%	107,129	54%
Black	584	33%	952	21%	57,671	29%
Hispanic	135	8%	524	11%	32,579	16%
Other/Unknown	12	1%	37	1%	2,027	1%
Age Group (years)						
Under 13	31	2%	101	2%	3,372	2%
13 - 19	1	0%	16	0%	758	0%
20 -29	335	19%	928	20%	39,177	20%
30 - 39	943	53%	2,286	49%	91,515	46%
40 - 49	362	20%	950	21%	44,228	22%
Over 49	110	6%	353	8%	20,356	10%

* Total Cases reported as of November 1, 1991

** Refers to the Boston Standard Metropolitan Statistical Area

UPDATE:

In December, fifty-five AIDS cases were reported to the AIDS Surveillance Program.

CALENDAR

"Treating HIV Clients: Identifying and responding to Social Worker's Stress."
Nat. Assoc. of Social Workers/New England Deaconess Hospital sponsored symposium to be held at th Audrey Kennedy Building New England Deaconess Hospital, 2/20, 8:00 a.m. - 4:30 p.m. For furthe information please call (617) 227-9635.

HIV Pre/Post Test Spanish/English Counseling Techniques Course
Latino Health Network/MDPH bilingual training course will be offered 1/29, 1/30, 1/31, 2/3 and 2/4. Pre-registration is required, please contact Evelyn Stein at (617) 262-9362.

Understanding HIV/AIDS as a Disability
MDPH and HIV/AIDS Disability Network sponsored workshop to be held 1/30 at the Massachusetts State Laboratory Building. Thre social work credits. For more information call Christie Burke at (617) 727-0368.

Every Monday, Support Group for HIV+ Women
Weekly support group for HIV+ women recovering from drug and alcohol addiction. No fee required. Please contact Magda or Christin of Women, Inc. at (617) 442-6166.

Adolescent Support Group
Support group for adolescents with someone in their family network who is HIV+. At Beth Israel Hospital. Sliding scale fee. Fo information please call (617) 735-2300 x1046.

Spanish/English AIDS Hotline
Individuals with HIV/AIDS looking for help should call (800) 637-3776.

Job Announcement:

HIV/AIDS Advocate - Responsible for outreach, supportive counseling, advocacy, referral, case management, and crisis interventio for individuals at high risk of HIV infection, individuals already infected and family members of these groups. Experience in AIDS/HIV work, fluency in Spanish and public health degree or experience required. For more information, please contact Adam Rice at th Brookside Community Health Center at (617) 522-4700 x280.

AIDS NEWSLETTER
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January
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AIDS NEWSLETTER

Vol. 7 No. 2 Monthly Publication of the Massachusetts Department of Public Health February, 1992

A Review of CDC HIV Seroprevalence Surveys (Part I)

This article is the second in a two-part series on HIV seroprevalence surveys in Massachusetts. Last month's edition of the ***AIDS NEWSLETTER*** featured an overview of the objectives and study design of a set of sentinel HIV serosurveys currently being conducted in the state, funded by the federal Centers for Disease Control. Data for fiscal year 1991 (FY91) from the serosurveys administered by the Massachusetts Department of Public Health, (Childbearing Women, Sexually Transmitted Disease Clinics, and Correctional Facilities), were discussed in the previous edition. This article will present FY91 data from those HIV serosurveys administered by the Boston Department of Health and Hospitals (BDHH), specifically, studies based in a tuberculosis (TB) clinic, women's health clinic, and three drug treatment centers. All sera are tested in the HIV Laboratory at the Massachusetts State Laboratory.

Tuberculosis Clinic Patients

Increases in TB cases have been reported in many parts of the United States. These increases have been occuring primarily in areas of high prevalence of HIV infection and AIDS.

Once infected with the TB organism, people who are immunocompromised, such as those with HIV infection, are at risk of progression from latent to active TB. While *lifetime* risk of developing active TB after TB infection is 5-10% in persons without HIV infection, the risk in those with HIV infection appears to be 7-10% *per year.*

TB infection and disease are categorized into five Classes for the purposes of surveillance and clinical follow up. Class 3 is proven active TB. Class 5 is presumptive TB awaiting confirmation and Class 2 is TB infection (positive skin test) without active disease. In the TB clinic serosurvey, the observed HIV seropositivity rate was seven times greater in patients with active TB, (Class 3 and 5) compared to those with latent TB (Class 2) infection (active TB=28%, 35/127 vs. latent TB=4.0%, 12/297).

Rates of HIV infection in TB clinic patients was roughly equal for men and women in the Class 3 and 5 population (males=29%, 25/86; females=24%, 10/41), but Class 2 males had a higher seropositivity rate than Class 2 females, 6.8% (10/147) and 1.4% (2/148) respectively. The highest rates of HIV infection were observed in 30-39 year olds (Table 1). Among Class 2 patients, hispanics (10.0%, 6/59) had twice the seropositivity rate of either whites (5.3%, 1/19) or blacks (3.8%, 4/104). In all TB infection groups, HIV infection rates for U.S.-born patients were higher than those of non-U.S. born patients (Table 1).

A history of intravenous drug use (IVDU) is highly associated with HIV infection among TB patients seen. Many patients reporting a history of IVDU also have lifestyles that may increase their risk for TB infection. For example, many live in shelters or other overcrowded situations where TB may spread readily. Among Class 2 TB patients 7/12 (58%) of the HIV seropositive reported a history of IVDU. Among Class 3 and 5 Survey of Risk Behavior (SRB) participants, the HIV seropositivity rate for patients reporting a history of injecting street drugs since 1978 was 67% (6/9) while for participants reporting no IVDU since 1978 the rate was 17% (8/46).

Inside:

- *Monthly Update....page 3*
- *Calendar..........page 4*

Next Month:
- *Case Management*

Women of Childbearing Age

Surveys of clinics are being conducted to determine the prevalence of HIV infection in patients attending clinics which serve sexually active women of reproductive age and to assess the type of risk factors for HIV infection in this population. Unlinked surveys and SRBs have been in progress since 1988 at family planning, prenatal, and abortion clinics.

Of the 2,605 sera tested in the unlinked studies, 63 (2.4%) were HIV positive. In the SRB, 11 of 180 (6.1%) samples tested positive. In both the unlinked and SRB studies, HIV-seropositivity rates for prenatal clinics were higher than those for either family planning or abortion clinics (Table 2). In addition, HIV prevalence rates for women in prenatal clinics were four (unlinked) to eight (SRB) times greater than the approximately 1% rate for inner-city Boston newborn infants (newborn screening data presented in the last issue). The higher HIV infection rates in the prenatal clinic group may be explained by the availability of special "high risk" prenatal services for participating IVDUs.

In the unlinked survey, 5.9% (16/272) of whites were HIV-seropositive compared to 2.4% (42/1785) of blacks and 1.2% (4/328) of hispanics. For SRB, 22% (5/23) of whites tested HIV-seropositive, a rate approximately seven times that seen in blacks (3.5%, 4/115) and almost four times that of hispanics (6.7%, 2/30). Cord blood serologies of babies delivered at Boston City Hospital showed slightly higher HIV infection rates in white (2.9%) than in black Americans (2.1%), and there was an increased HIV infection rate associated with IVDU.

Drug Treatment Program Surveys

Unlinked surveys measuring HIV positivity rates in sera from new entrants to drug treatment programs are being conducted at a public program and two private programs in Massachusetts. In addition, an SRB is in progress at two sites. All three programs offer methadone treatment.

The observed HIV seropositivity rate among unlinked samples was 18% (131/713). Rates of HIV infection were similar among the three clinics: 20% (85/426), 15% (36/235), and 19% (10/52) respectively. HIV seroprevalence rates were higher in males, 20% (90/443) than females, 14% (37/269). The majority of HIV-seropositives, 95% (125/131) were 25-44 years old. HIV infection rates were highest in hispanics, 40% (25/62), followed by blacks (30%, 24/80) and whites (15%, 82/564) respectively.

The seroprevalence rate in the SRB was 6.0% (15/251). HIV prevalence in men (7.9%, 11/139) was more than double the rate observed in women (3.6%, 4/111). Of SRB participants who were born in the United States, 4.5% (10/224) were HIV positive, compared to 19% (5/26) of foreign born participants.

Table 1: HIV Seroprevalence in TB Clinic Patients

	CLASS		
AGE	3/5	2	3/5 SRB
<20	0%	0%	0%
20-29	25%	6%	14%
30-39	52%	7%	48%
40-49	41%	6%	17%
50-59	0%	0%	0%
60+	13%	0%	14%
UNK	14%	0%	0%
BIRTHPLACE			
U.S.	34%	9%	27%
Foreign	22%	3%	24%

Table 2: HIV Seroprevalence in Women's Health Clinics

	Family Planning	Abortion	Prenatal
Unlinked:	2%	2%	4%
	(20/1098)	(11/656)	(32/851)

For more information about the HIV seroprevalence surveys administered by BDHH, please call Dr. Anita Barry at (617) 534-5611 or Kathleen Steger at 534-4800.

AIDS SURVEILLANCE SUMMARY

	Boston		Massachusetts		United States*	
Total Cases reported as of 2/1/92	1,812		4,753		202,843	
	No.	%	No.	%		
Residence						
City of Boston	1,812		1,812	38%		
Remainder of Boston SMSA**			1,127	24%		
Remainder of Massachusetts			1,512	32%		
Subtotal	1,812		4,451	94%		
Out-Of-State			302	6%		
Transmission Mode (Adult)	1,781		4,651		199,417	
Homosexual/Bisexual Male	1,093	61%	2,610	56%	116,609	58%
I.V. Drug User	338	19%	1,072	23%	44,791	22%
Homosexual I.V. Drug User	65	4%	192	4%	12,953	6%
Hemophiliac	8	0%	62	1%	1,680	1%
Heterosexual	197	11%	431	9%	11,609	6%
Blood Transfusion Recipients	18	1%	112	2%	4,306	2%
Undetermined	62	3%	172	4%	7,469	4%
Transmission Mode (Pediatric)	31		102		3,426	
Mother with AIDS/at risk for HIV	29	94%	88	86%	2,839	83%
Hemophiliac	0	0%	5	5%	163	5%
Blood Transfusion Recipient	2	6%	9	9%	288	8%
Undetermined	0	0%	0	0%	83	2%
Gender						
Male	1,604	89%	4,149	87%	180,531	89%
Female	208	11%	604	13%	22,312	11%
Mortality Status						
Alive	670	37%	1,815	38%	72,156	36%
Dead	1,142	63%	2,937	62%	130,687	64%
Race/Ethnicity						
White	1,070	59%	3,204	67%	108,788	54%
Black	593	33%	974	20%	58,791	29%
Hispanic	137	8%	538	11%	33,204	16%
Other/Unknown	12	1%	37	1%	2,060	1%
Age Group (years)						
Under 13	31	2%	102	2%	3,426	2%
13 - 19	1	0%	16	0%	768	0%
20 -29	339	19%	945	20%	39,768	20%
30 - 39	960	53%	2,349	49%	93,118	46%
40 - 49	368	20%	978	21%	45,068	22%
Over 49	113	6%	363	8%	20,695	10%

* Total Cases reported as of December 1, 1991

** Refers to the Boston Standard Metropolitan Statistical Area

UPDATE:

In January, one hundred and twenty-one AIDS cases were reported to the AIDS Surveillance Program.

CALENDAR

"Housing Options for People with HIV/AIDS" Statewide HIV/AIDS Educational Series. March 12, 1 p.m.- 4 p.m., State Laboratory Building, Jamaica Plain. For more information call Christie Burke at (617) 727-0368.

"The AIDS Epidemic: From Research to Practice" American Association for Dental Research sponsored program to be held at the Hynes Convention Center, March 14. For information and registration please call (202) 898-1050.

"HIV/AIDS in the Dental Setting" A faculty development program for dentists and dental hygienists to be held in the Manceshter/Nashua, NH area on April 26, 27, and 28. CEU's will be given. For more information please contact Kelly Fattman at (508) 856-3255.

Weekly Support Group for HIV+ Women Meets every Monday for women recovering from drug and alcohol addiction. No fee required. Please contact Magda or Christine of Women, Inc. at (617) 442-6166.

Adolescent Support Group For adolescents with a family network member who is HIV+. Meets at Beth Israel Hospital. Sliding scale fee. For information please call (617) 735-2300 x1046.

Spanish/English AIDS Hotline Individuals with HIV/AIDS looking for help should call (800) 637-3776.

HIV Dental Ombudsperson Program Individuals with HIV/AIDS having trouble accessing or affording dental care can call (617) 534-4717 for help.

Job Announcements:

HIV/AIDS Advocate - Responsible for outreach, supportive counseling, advocacy, referral, case management, and crisis intervention for individuals at high risk for HIV infection, individuals already infected and family members of these groups. Experience in AIDS/HIV work, fluency in Spanish and public health degree or experience required. For more information, please contact Adam Rice at the Brookside Community Health Center at (617) 522-4700 x280.

AIDS Epidemiologist - The Massachusetts AIDS Surveillance Program has an opening for an AIDS Epidemiologist. If you are interested in applying please call (617) 522-3700 x487 or send a resume and cover letter to the AIDS Surveillance Program at the Massachusetts Department of Public Health.

AIDS NEWSLETTER
is a publication of the
AIDS Surveillance Program

February
1992

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AIDS NEWSLETTER

Vol. 8 No. 3 Monthly Publication of the Massachusetts Department of Public Health March, 1992

Case Management for People with HIV Disease

Case management has become a primary means of responding to the needs of people with HIV disease. Case management refers to a system in which one person is designated as an ongoing resource to ensure each client access to the full range of services for the duration of HIV illness. The purpose is to remove obstacles in obtaining services.

Though there is agreement that case management should be an integral part of any comprehensive care system for people with HIV disease, there are no universal standards established for the day to day responsibilities of the case manager. This is both a reflection of the diverse needs of individuals with HIV disease and the variation in resources, and agencies where case managers are based.

While no precise definition of case management exists, there are standard functional elements:

- Assessment of client needs,
- Development of a care plan for these needs,
- Assistance to clients in obtaining information, referrals, and services,
- Regular contact with clients to ensure ongoing support and to make changes as needed.

Several factors make HIV disease case management more complicated and essential:

- *Social isolation:* The stigma of HIV and of the person's sexuality or addiction can create barriers to access of services. Subsequent isolation can create an unusual degree of dependency on a case manager.

- *Medical needs are extremely complex:* The course of the illness is unpredictable and erratic, and causes dramatic changes in the type and level of services needed. People often have several opportunistic infections simultaneously. Furthermore, treatment standards vary and clients are faced with complex medical decisions based on very technical information.

- *Support systems are strained by the epidemic:* People who make up the support system of a person with HIV infection may be sick or may have died. The client may be helping to care for their partner, child, or close friends while managing their own needs. In addition, friends that they rely on for support may be simultaneously caring for other people with HIV disease.

- *HIV may be one of many problems clients face:* HIV is often only one, and not necessarily the most urgent of many survival issues clients are facing. Such problems include inadequate housing, chemical dependency, and poverty.

Inside:

- *Monthly Update....page 3*
- *Calendar..........page 4*

Next Month:

- *Adolescents and HIV*

For case reporting of AIDS patients meeting the CDC definition, please notify AIDS Epidemiologists at (617)522-3700, ext. 482 or 478.

- *Diverse needs of a diverse caseload:* Case managers must adapt the relationship to the specific needs of each client. The level of involvement of the case manager with each client will depend on:
    - a) health status and degree of functional impairment,
    - b) degree of involvement of friends and family in providing support,
    - c) degree to which basic needs, such as housing and food are being met,
    - d) barriers to service access due to cultural or linguistic differences, race, sex, or sexual orientation,
    - e) client's ability to negotiate services for themselves.

Not everyone with HIV disease needs or wants the involvement of a case manager, however most do need access to information about resources that are available to them, and service referrals relevant to their particular circumstance. When clients become more seriously ill, comprehensive case management becomes more crucial as clients becomes less able to manage their lives independently and concomitantly, their needs become more complicated. The greatest need for intensive case management is often at the time of initial diagnosis and later when the disease has progressed to impair a person's ability to function independently.

The effectiveness of a case manager is determined by a number of factors, many of which are not under their control. The ability of case managers to address the needs of their clients is severely limited at the onset. Case management alone cannot solve the problems of fragmented, uncoordinated care, nor the deficiencies that exists in the human service systems. It is not the clients or 'cases' that need to be managed, but the service systems.

Several key issues that shape the quality and effectiveness of case management are:

- *Resources available:* Case management is ineffective without the availability of essential services such as financial assistance, housing, drug treatment, child care, transportation, and home care.
- *Reasonable caseload:* Case managers must maintain sufficient contact with each client in order to remain proactive in their care planning and not crisis oriented.
- *Level of collaboration with other key providers.*
- *Holistic approach to clients and their environment:* The needs of the partner and family members are often neglected by the care system, at the same time that the burden of care often falls on them. Case managers should be a resource for the people involved in supporting the client.
- *Knowledge of existing resources, access, and eligibility requirements:* People with HIV disease and their family and friends are confronted with unfamiliar and complex service delivery systems. In order to make realistic and optimal choices they must have adequate information.
- *Counseling skills and a knowledge of the medical and psychological consequences of HIV disease:* A key role of the case manager is to help clients adjust to transitions and losses that occur over the course of the illness. Case managers not only need to know the resources but also understand the psychological ramifications of getting services. A client's acknowledgement of need for a service often means coming to terms with the decline of their health and feelings of loss of control over their life.
- *Ability to earn the trust of each client:* Case managers working with HIV infected people must have an ability to establish relationships and earn the trust of individuals with different cultural and socioeconomic backgrounds, histories of substance use, and alternative sexual orientations. Most people affected by HIV disease are already disenfranchised to some extent--addicts, gay men, people of color, women--and are likely to be somewhat apprehensive about going for services for fear of being subjected to prejudice or mistreatment. Case managers must be aware of their own biases and not impose them on their clients in order to convey respect and maintain a non-judgmental attitude.
- *Adequate supervision, training and support for the case manager:* Case management for people with HIV disease is a daunting challenge given the complexities of the disease and the lack of many services. It involves a level of knowledge, skill, and self-reflection that requires ongoing supervision and training. Case managers are expected to be able to fulfill the needs of their clients despite inadequate or non-existent resources. They must simultaneously cope with their clients' emotional needs that are inherently part of the job, and to be able to accept the reality that no matter what they do, there will likely still be unmet needs.

AIDS SURVEILLANCE SUMMARY

	Boston		Massachusetts		United States*	
Total Cases reported as of 3/1/92	1,839		4,829		206,392	
	No.	%	No.	%		
Residence						
City of Boston	1,839		1,839	38%		
Remainder of Boston SMSA**			1,144	24%		
Remainder of Massachusetts			1,544	32%		
Subtotal	1,839		4,527	94%		
Out-Of-State			302	6%		
Transmission Mode (Adult)	1,808		4,725		202,921	
Homosexual/Bisexual Male	1,106	61%	2,639	56%	118,362	58%
I.V. Drug User	346	19%	1,100	23%	45,753	23%
Homosexual I.V. Drug User	65	4%	195	4%	13,135	6%
Hemophiliac	8	0%	62	1%	1,713	1%
Heterosexual	199	11%	442	9%	11,936	6%
Blood Transfusion Recipients	18	1%	112	2%	4,347	2%
Undetermined	66	4%	175	4%	7,675	4%
Transmission Mode (Pediatric)	31		104		3,471	
Mother with AIDS/at risk for HIV	29	94%	90	87%	2,936	85%
Hemophiliac	0	0%	5	5%	163	5%
Blood Transfusion Recipient	2	6%	9	9%	289	8%
Undetermined	0	0%	0	0%	83	2%
Gender						
Male	1,628	89%	4,212	87%	183,569	89%
Female	211	11%	617	13%	22,823	11%
Mortality Status						
Alive	656	36%	1,798	37%	73,159	35%
Dead	1,183	64%	3,031	63%	133,233	65%
Race/Ethnicity						
White	1,086	59%	3,244	67%	110,385	53%
Black	599	33%	992	21%	60,037	29%
Hispanic	142	8%	556	12%	33,878	16%
Other/Unknown	12	1%	37	1%	2,092	1%
Age Group (years)						
Under 13	31	2%	104	2%	3,471	2%
13 - 19	1	0%	16	0%	789	0%
20 -29	344	19%	960	20%	40,362	20%
30 - 39	969	53%	2,385	49%	94,720	46%
40 - 49	377	21%	997	21%	46,001	22%
Over 49	117	6%	367	8%	21,049	10%

* Total Cases reported as of January 1, 1992

** Refers to the Boston Standard Metropolitan Statistical Area

UPDATE:

In February, seventy-eight AIDS cases were reported to the AIDS Surveillance Program.

CALENDAR

"HIV - STD Connection: Social and Medical Perspectives" Statewide HIV/AIDS Educational Series. April 15, 9 a.m. - 1 p.m., State Laboratory Building, Jamaica Plain. For more information call Christie Burke at (617) 727-0368.

"HIV/AIDS in the Dental Setting" A faculty development program for dentists and dental hygienists to be held in the Manchester/Nashua, NH area on April 26, 27, and 28. CEU's will be given. For more information please contact Kelly Fattman at (508) 856-3255.

"How to Comply with the OSHA Bloodborne Pathogen Standard" Infection Control Consultants of America sponsored program to be held at the Sturbridge Host Conference Center, May 7, 1992. Please call (508) 443-0176.

Weekly Support Group for HIV+ Women Weekly Monday meeting for women recovering from drug and alcohol addiction. No fee required. Please contact Magda or Christine of Women, Inc. at (617) 442-6166.

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Professional AIDS Care Givers Support Group Meets bimonthly at the Packard Manse in Stoughton, call Amy Cabral at (508) 586-9855.

AIDS NEWSLETTER
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AIDS NEWSLETTER

Vol. ~~7~~ 8 No. 4 Monthly Publication of the Massachusetts Department of Public Health April, 1992

AIDS in Adolescents and Young Adults

Adolescence is a time when sexual activity and experimentation with drugs and alcohol may begin. National studies of adolescents have found increased rates of sexual activity, earlier age of initiation of sexual intercourse, increased number of sexual partners, and inconsistent use of condoms. In addition, other risk behaviors for HIV acquisition such as illicit drug use or exchange of sex for drugs or money may begin during the teen years.

There is not adequate data on HIV infection in adolescents. Because the incubation period from HIV infection to AIDS can be 10 years or longer, AIDS surveillance data is a 'lagging' indicator for HIV infection rates. Information from voluntary HIV counseling and testing and seroprevalence surveys is limited to persons self-identified as "at risk" and may not be representative of the general adolescent and young adult populations.

In this months AIDS Newsletter, we will summarize data from AIDS cases aged 13-24. In next month's issue seroprevalence data for adolescents and young adults will be reviewed.

AIDS SURVEILLANCE DATA

Through March 1992, only 16 cases (<1%) of AIDS have been diagnosed in adolescents (aged 13-19) in Massachusetts. However, 20% of all Massachusetts residents diagnosed with AIDS (cumulatively 902 cases as of 3/1/92) have been between the ages of 20-29. One hundred and seventy-six cases of AIDS have been reported in persons aged 20-24. Most of these persons were probably infected with HIV during their adolescence.

Inside:

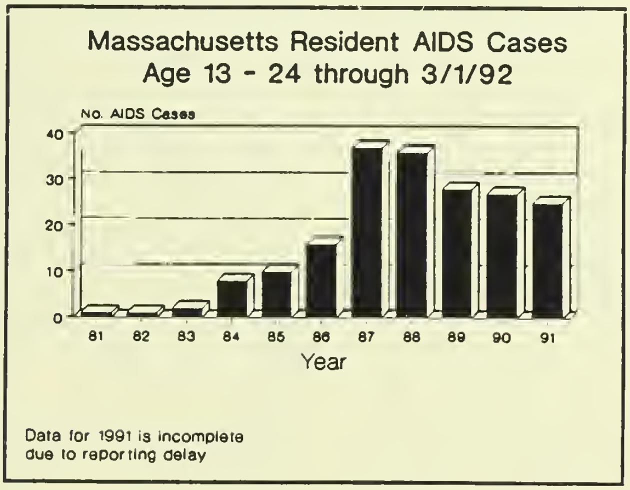
- *Monthly Update....page 3*
- *Calendar..........page 4*

Next Month:

- *HIV Infection in Adolescents*

Figure 1. shows the number of AIDS cases diagnosed each year in persons aged 13-24. The number of AIDS cases reported in this age group steadily increased through 1987 and 1988 but has since been decreasing. During 1991, 25 cases of AIDS were reported in 13-24 year olds. Unfortunately, decreasing rates of infection may not explain this trend. Longer periods of asymptomatic infection, especially in young adults may be delaying AIDS-defining conditions.

Figure 1.



Data for 1991 is incomplete due to reporting delay

Seventy-eight percent (n= 150) of AIDS cases aged 13-24 are males; 22% are females. Of these 64% of those cases have died. As with many other age groups, adolescents and young adults from communities of color are

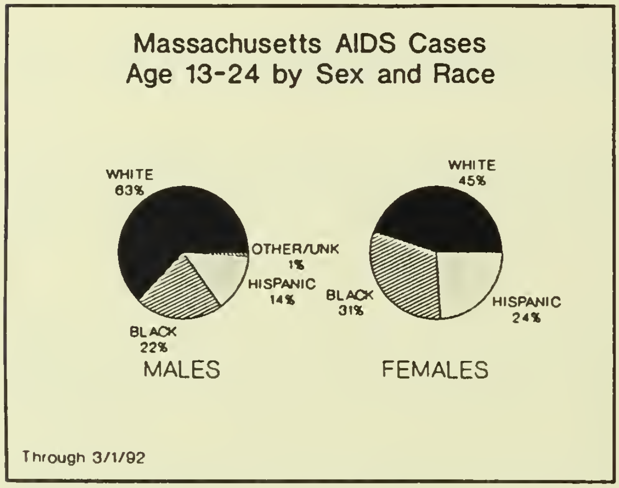
* * * * * *

UPDATE: The implementation of a proposed expanded CDC AIDS Case definition has been postponed to an undetermined date.

For case reporting of AIDS patients meeting the CDC definition, please notify AIDS Epidemiologists at (617)522-3700, ext. 482 or 478.

disproportionately affected by the AIDS epidemic. Thirty-seven percent of males and fifty-five percent of female AIDS cases aged 13-24 are from communities of color. Figure 2. shows the race/ethnicity of males and females with AIDS in this age group.

Figure 2.



Sixty-nine percent of AIDS cases aged 13-19 are due to the receipt of contaminated blood products (primarily for the treatment of clotting disorders); thirteen percent were related to injecting drug use (IDU). These figures contrast sharply with the risk profiles for AIDS cases aged 20-24. In this group, 35% of cases report homo/bisexuality as their risk for HIV acquisition. IDU and receipt of contaminated blood products accounted for 33% and 6% of these AIDS cases respectively. As would be expected reported risk behaviors varied for the sexes. IDU and heterosexual contact with an IDU is the predominant risk behavior for female AIDS cases aged 13-24. Seventy-two percent of this group report that IDU is either directly or indirectly responsible for their acquisition of HIV infection (48% IDU, 24% sex with IDU). Heterosexual transmission is believed to be responsible for an additional 20% of female cases.

Among male AIDS cases in the same age group IDU accounted for only 20% of infections. Sexual contact with men, heterosexual contact, and a combination of sex with males and IDU were responsible for disease acquisition in 45%, 9%, and 7% of 13-24 AIDS cases respectively.

Boston residents account for 31% of adolescent and young adult AIDS cases (38% of Massachusetts AIDS cases are reported among Boston residents). Sixty-two cities and towns in Massachusetts have reported at least one AIDS case in the 13-24 year age group.

Conclusions:

AIDS Surveillance Program data indicates that:

- Adolescents and young adults from communities of color are disproportionately affected by the AIDS.
- Transmission modes for AIDS cases differ greatly between adolescents and young adults. Sixty-nine percent of AIDS cases aged 13-19 are attributable to the receipt of contaminated blood products. In persons aged 20-24, 35% of cases reported homo/bisexuality, 33% were IDUs and only 6% had received contaminated blood products.

- Females adolescents and young adults with AIDS are more likely to be related to IDU (72%) than male AIDS cases in the same age group (20%).

To date, very few cases of AIDS in adolescents have been reported in Massachusetts. However, the increased number of AIDS cases in persons aged 20-24 indicates that many persons may be acquiring their HIV infection during adolescence when risk behaviors for HIV acquisition are first initiated.

MA Health Facilities with more than 75 Reported Cumulative AIDS Cases

New England Deaconess	545
Boston City Hospital	465
Mass. General Hospital	422
Beth Israel Hospital	319
Brigham and Women's	309
Baystate Medical Center	207
Fenway Community Health	203
New England Medical Center	196
UMASS Medical Center	154
Harvard Community Health	151
Lemuel Shattuck Hospital	147
V.A. Medical Centers	113
St. Luke's Hospital	89
Mt. Auburn Hospital	88
Total	3,408*

*Represents 70% of MA Cases

AIDS SURVEILLANCE SUMMARY

	Boston		Massachusetts		United States*	
Total Cases reported as of 4/1/92	1,861		4,894		213,641	
	No.	%	No.	%		
Residence						
City of Boston	1,861		1,861	38%		
Remainder of Boston SMSA**			1,166	24%		
Remainder of Massachusetts			1,565	32%		
Subtotal	1,861		4,592	94%		
Out-Of-State			302	6%		
Transmission Mode (Adult)	1,829		4,787		210,043	
Homosexual/Bisexual Male	1,123	61%	2,677	56%	122,405	58%
I.V. Drug User	351	19%	1,118	23%	47,309	23%
Homosexual I.V. Drug User	66	4%	198	4%	13,546	6%
Hemophiliac	8	0%	63	1%	1,775	1%
Heterosexual	202	11%	447	9%	12,510	6%
Blood Transfusion Recipients	18	1%	113	2%	4,476	2%
Undetermined	61	3%	171	4%	8,022	4%
Transmission Mode (Pediatric)	32		107		3,598	
Mother with AIDS/at risk for HIV	30	94%	93	87%	3,048	85%
Hemophiliac	0	0%	5	5%	169	5%
Blood Transfusion Recipient	2	6%	9	8%	294	8%
Undetermined	0	0%	0	0%	87	2%
Gender						
Male	1,645	88%	4,261	87%	189,929	89%
Female	216	12%	633	13%	23,712	11%
Mortality Status						
Alive	661	36%	1,791	37%	75,246	35%
Dead	1,200	64%	3,103	63%	138,395	65%
Race/Ethnicity						
White	1,098	59%	3,287	67%	114,205	53%
Black	607	33%	1,005	21%	62,333	29%
Hispanic	143	8%	564	12%	34,940	16%
Other/Unknown	13	1%	38	1%	2,163	1%
Age Group (years)						
Under 13	32	2%	107	2%	3,598	2%
13 - 19	1	0%	16	0%	808	0%
20 -29	347	19%	973	20%	41,628	19%
30 - 39	978	53%	2,413	49%	98,049	46%
40 - 49	386	21%	1,015	21%	47,763	22%
Over 49	117	6%	370	8%	21,795	10%

* Total Cases reported as of March 1, 1992

** Refers to the Boston Standard Metropolitan Statistical Area

UPDATE:

In March, sixty-seven AIDS cases were reported to the AIDS Surveillance Program.

CALENDAR

"Substance Abuse, Sex and HIV" Statewide HIV/AIDS Educational Series. May 22, 9 :30 a.m. - 1 :30 p.m., State Laboratory Building, Jamaica Plain. For more information call Christie Burke at (617) 727-0368.

"Meeting the Needs of the HIV Infected Client" An education conference for care providers and clients. Thursday, May 21, 8:00 a.m. - 4:30 p.m. at the King's Grant Inn, Danvers, MA registration required, call (508) 741-1200 x4137 or 3026.

"Tuberculosis and the HIV Connection" The Boston Department of Health and Hospitals offers a TB Seminar at your health care facility with CEU's. For more information please call David DeBiasi at (617) 534-5916.

"Building Alliances II" Boston HIV/AIDS and Disability Network sponsored second statewidew conference for people with HIV/AIDS and other disabilities to be held on May 12 and 13 at the Worcester Marriott Hotel. For information please call (617) 727-6374.

"How to Comply with the OSHA Bloodborne Pathogen Standard" Infection Control Consultants of America sponsored program to be held at the Sturbridge Host Conference Center, May 7, 1992. Please call (508) 443-0176.

Weekly Support Group for HIV+ Women Weekly Monday meeting for women recovering from drug and alcohol addiction. No fee required. Please contact Magda or Christine of Women, Inc. at (617) 442-6166.

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Professional AIDS Care Givers Support Group Meets bimonthly at the Packard Manse in Stoughton, call Amy Cabral at (508) 586-9855.

Massachusetts AIDS Discrimination Hotline If you feel that you or your client is being discriminated against due to their HIV/AIDS status and need help, call, (800) AIDS-808.

Job Announcement HIV Nurse/Case Manager The Cambridge VNA is looking for an HIV-experienced RN for a full-time position information please call Ken Trask at the Cambridge VNA at (617) 547-2620.

AIDS NEWSLETTER
is a publication of the
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April
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AIDS NEWSLETTER

Vol. ~~7~~ 8 No. 5 Monthly Publication of the Massachusetts Department of Public Health May, 1992

HIV in Adolescents and Young Adults

Information on HIV seroprevalence in Massachusetts is available from a variety of sources. Some of these sources provide us with information about the prevalence of HIV in adolescents and young adults in certain selected populations.

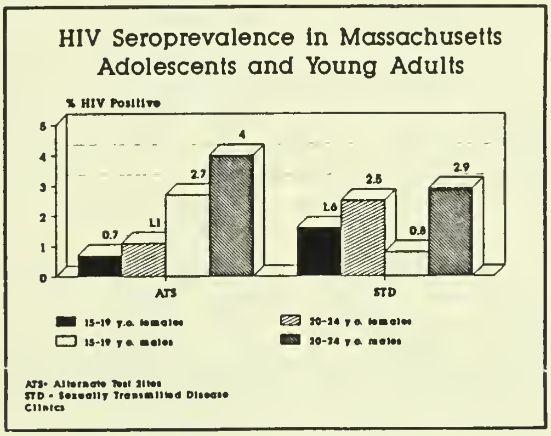
Counseling and Testing Data

Anonymous counseling and testing (C&T) for antibody to HIV has been available at state-funded Alternate Test Sites (ATS) beginning in April of 1985. Since that time, almost 1000 adolescents (aged 15-19 years) have been tested for HIV antibodies. One percent of these adolescents have been found to be HIV positive. The seroprevalence rate increases to 2.7% (160/5846) in individuals aged 20-24.

Seroprevalence rates vary by sex and age in persons receiving C&T in this setting as is illustrated in Figure 1. Rates range from a low of 0.7% in females aged 15-19 to 4.0% in 20-24 year old males. Risk behaviors, as expected, also have an impact on the seroprevalence rates in this age group. Homo/bisexual males have seropositivity rates of 3.7% and 6% in the 15-19 and 20-24 year old age groups respectively. Injecting drug users (IDUs), aged 15-19 have seroprevalence rates of 6%; this rate is 4.7% in 20-24 year old IDUs.

Individuals have also been able to receive confidential HIV C&T at state-funded Sexually Transmitted Disease (STD) clinics since 1987. To date, 1169 persons under the age of 20 have been tested for HIV infection in these settings. Fourteen (1.2%) of these adolescents have been positive for antibody to HIV. As with data from the ATS program, seroprevalence rates vary by sex and age. Figure 1. shows the HIV seropositivity rates for male and female adolescents and young adults receiving C&T in STD clinics. Males aged 15-19 have seroprevalence of .8% compared with 1.6% for females in the same age range. Rates increase with age to 2.9% and 2.5% in 20-24 year old males and females respectively.

Figure 1.



Homo/bisexual males and IDUs have the highest seroprevalence rates among adolescents and young adults receiving HIV testing in STD clinics. Rates in 15-19 year olds are 4% and 3.8% in homo/bisexual males and IDUs, respectively. Once again, seroprevalence rates increase with age ; 11.5% of homo/bisexual males and 14.4% of IDUs aged 20-24 were HIV positive. HIV seroprevalence rates in ATS and STD clinics are higher in persons from communities of color. Seropositivity rates for HIV by race in ATS are as follows: white 2.1%, black 6.0%, hispanic 5.3%. Rates for STD patients are 1.8%, 3.7% and 2.7%, respectively.

Blinded Serosurveys

Blinded serosurveys for the presence of HIV antibody in selected STD clinics are another source of data about HIV seroprevalence in adolescents and young adults (see the January and February 1992 issues of the AIDS Newsletter for more information). Data collected since September 1988 reveal that 0.4% of the 2495 15-19 year olds seen in these clinics were HIV antibody positive. Seroprevalence rates in males and females in this group are the same, but like previously reported data, vary by race and risk. Black

Inside:

- *Monthly Update....page 3*
- *Calendar..........page 4*

Next Month:
- *HIV-2*

For case reporting of AIDS patients meeting the CDC definition, please notify AIDS Epidemiologists at (617)522-3700, ext. 482 or 478.

adolescents had a seroprevalence rate of 0.7%, over three times that of the 0.2% noted in white teenagers. In this age group, persons who reported having sex with a high risk partner (i.e. IDU, bisexual male) have the highest seroprevalence rate of 1.3%. Seroprevalence rates increase in persons aged 20-24 within which an overall seroprevalence rate of 1.6% is noted; 1.5% of males (59/4045) and 2% of females (34/1685) were seropositive. Persons with a known HIV positive partner had the highest seroprevalence rate (27.3%) followed by homo/bisexual men (17.8%), IDUs (14.4%) and persons reporting multiple heterosexual partners (1.1%). Rates in this age group vary by race and are as follows: white (1.1%), black (2.0%), hispanic (1.7%).

HIV Testing of Civilian Applicants for the Military Service

Nationwide testing of civilian applicants for military service also provides us with some estimates of the extent of HIV infection in adolescents and young adults. The Department of Defense in conjunction with the Division of HIV/AIDS, CDC, compiles seroprevalence data for each state and metropolitan area in the United States (1). For the period October 1985 through September 1991, Massachusetts applicants aged 17-19 had an HIV seroprevalence rate of 0.02%. 20-24 year old applicants had a seropositivity rate of 0.09%. These rates compare with a nationwide average of 0.03% and 0.15% for military applicants aged 17-19 and 20-24 respectively.

In this population HIV infection rates vary by sex. Table 1 shows HIV seropositivity rates for 17-19 and 20-24 year old military recruits by sex. These data suggest that HIV seroprevalence in Massachusetts female military applicants is higher than that in comparably aged Massachusetts male recruits and also higher than the national average for these groups of women. Conversely, male applicants to the military from Massachusetts have lower seropositivity rates compared to similarly aged males from the entire United States.

Table I

HIV Seroprevalence Rates
Among Military Applicants
(% seropositive)

Group	Massachusetts	USA
17-19 yrs. (male)	0.02	0.03
17-19 yrs. (female)	0.09	0.03
20-24 yrs. (male)	0.09	0.16
20-24 yrs. (female)	0.13	0.08

Screening of Persons in the U.S. Job Corp

The Job Corp is a federally funded educational program for socioeconomically disadvantaged 16-21 year olds. HIV antibody screening in all residential centers of the Job Corp began in March of 1987. From October 1987 through December 1991, 3145 Massachusetts corps members have been HIV antibody tested, an overall seroprevalence rate of 0.41% (4.1 per 1000) was noted. Seroprevalence rates were similar for males and females. During the same time period an overall seroprevalence rate of .33% (3.3 per 1000) was noted for the U.S.(CDC, unpublished data).

A recent study by St. Louis et al (2) reveals that in this group HIV seroprevalence rates are higher in corpsmen from communities of color, from the Northeast (including Massachusetts) and in urban areas. State-specific seroprevalence rates for these groups have not been published.

Conclusions

Information on HIV seroprevalence in adolescents and young adults is available from a variety of sources but these sources may be biased with respect to the general population of adolescents and young adults because of self-selection. For example, teens utilizing ATS and STD clinics may voluntary choose HIV testing since they perceive themselves to be at risk for HIV. On the contrary, because active drug users, homosexuals, and high school drop-outs are excluded from the military, and because applicants are told of the requirement for mandatory HIV testing, seroprevalence rates observed in this population may be lower than in a similarly-aged general population cohort since the persons at the highest risk for HIV would not be included. HIV seroprevalence data from the sources discussed above reveal the following:

1. HIV seroprevalence increases with age indicating that persons are acquiring HIV infection during late adolescence.

2. Data from all sources indicate that HIV seroprevalence rates are higher in adolescents and young adults from communities of color than in similarly aged white youth.

3. Based on information obtained about seroprevalence rates in persons with different risk behaviors, it appears that sexual contact is an important factor in the acquisition of HIV infection in adolescents and young adults.

4. The overall seroprevalence rate for Massachusetts teens (<20 y.o.) is most likely between 0.02% (.2 per 1000), the rate in military recruits, and 1.2% (12 per 1000), that of STD clinic patients.

References: 1. USDHHS. Prevalence of HIV-1 Antibody in Civilian Applicants for Military Service, October 1985-September 1991.

2. St. Louis, ME, Conway, GA, Hayman, CR, Miller c, Peterson LR, and Dondero, TJ. Human Immunodeficiency Virus Infection in Disadvantaged Adolescents; Findings from the U.S. Job Corp JAMA, 1991, 266:2387-2391.

AIDS SURVEILLANCE SUMMARY

	Boston		Massachusetts		United States*	
Total Cases reported as of 5/1/92	1,880		4,965		218,301	
	No.	%	No.	%		
Residence						
City of Boston	1,880		1,880	38%		
Remainder of Boston SMSA**			1,186	24%		
Remainder of Massachusetts			1,595	32%		
Subtotal	1,880		4,661	94%		
Out-Of-State			304	6%		
Transmission Mode (Adult)	1,848		4,858		214,609	
Homosexual/Bisexual Male	1,132	61%	2,722	56%	124,961	58%
I.V. Drug User	359	19%	1,139	23%	48,312	23%
Homosexual I.V. Drug User	67	4%	204	4%	13,823	6%
Hemophiliac	8	0%	63	1%	1,812	1%
Heterosexual	204	11%	452	9%	12,881	6%
Blood Transfusion Recipients	18	1%	113	2%	4,537	2%
Undetermined	60	3%	165	3%	8,283	4%
Transmission Mode (Pediatric)	32		107		3,692	
Mother with AIDS/at risk for HIV	30	94%	93	87%	3,133	85%
Hemophiliac	0	0%	5	5%	173	5%
Blood Transfusion Recipient	2	6%	9	8%	296	8%
Undetermined	0	0%	0	0%	90	2%
Gender						
Male	1,661	88%	4,326	87%	193,994	89%
Female	219	12%	639	13%	24,307	11%
Mortality Status						
Alive	636	34%	1,770	36%	77,078	35%
Dead	1,244	66%	3,195	64%	141,223	65%
Race/Ethnicity						
White	1,110	59%	3,336	67%	116,542	53%
Black	612	33%	1,016	20%	63,941	29%
Hispanic	145	8%	574	12%	35,582	16%
Other/Unknown	13	1%	39	1%	2,236	1%
Age Group (years)						
Under 13	32	2%	107	2%	3,692	2%
13 - 19	1	0%	16	0%	821	0%
20 -29	352	19%	982	20%	42,462	19%
30 - 39	987	53%	2,450	49%	100,219	46%
40 - 49	391	21%	1,037	21%	48,889	22%
Over 49	117	6%	373	8%	22,218	10%

* Total Cases reported as of April 1, 1992

** Refers to the Boston Standard Metropolitan Statistical Area

UPDATE:

In April, seventy AIDS cases were reported to the AIDS Surveillance Program.

CALENDAR

"Women and HIV: Clinical Issues" Statewide HIV/AIDS Educational Series. June 25, State Laboratory Building, Jamaica Plain. For more information call Christie Burke at (617) 727-0368.

"Tuberculosis and the HIV Connection" The Boston Department of Health and Hospitals offers a TB Seminar at your health care facility with CEU's. For more information please call David DeBiasi at (617) 534-5916.

Weekly Spiritual Support Group for PWAs/HIV+ Individuals and their Caregivers offered by the Boston Catholic Archdiocese. Meets every Tuesday at 7:30 p.m. No fee required. For information please call (617) 482-5440.

Weekly Support Group for HIV+ Women Weekly Monday meeting for women recovering from drug and alcohol addiction. No fee required. Please contact Magda or Christine of Women, Inc. at (617) 442-6166.

Spanish/English AIDS Hotline Individuals with HIV/AIDS looking for help should call (800) 637-3776.

HIV Dental Ombudsperson Program Individuals with HIV/AIDS having trouble accessing or affording dental care can call (617) 534-4717 for help.

Biweekly Support Group for people with HIV infection meets first and third Thursday from 6:30 to 8:30 p.m. at the Neponset Health Center. In addition, a support group for family and friends of HIV infected individuals meets monthly. Please call Patsy Sullivan at (617) 282-3200.

Professional AIDS Care Givers Support Group Meets bimonthly at the Packard Manse in Stoughton, call Amy Cabral at (508) 586-9855.

Information/Discussion Group Four consecutive weeks in June for individuals who have family or friends with HIV/AIDS. No fee. Please call Jo at the Neponset Health Center (617-282-3200).

Massachusetts AIDS Discrimination Hotline If you feel you or your client are being discriminated against due to HIV or AIDS, call (800) AIDS-808 for help.

Job Announcement HIV Nurse/Case Manager & HIV Program Coordinator The VNA of Greater Lynn is looking for two HIV-experienced RNs. For information please call Chris Guercio at (617) 598-2454.

AIDS NEWSLETTER
is a publication of the
AIDS Surveillance Program
May
1992

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AIDS NEWSLETTER

Vol. 8 No. 6 Monthly Publication of the Massachusetts Department of Public Health June, 1992

Detection and Identification of HIV-2 Infection

Human Immunodeficiency Virus, Type 2, or HIV-2 is a retrovirus similar to HIV-1 in terms of structure, transmission and pathogenicity. Infected individuals develop AIDS often after a long incubation period. Worldwide, HIV-2 has been transmitted sexually, by needle-sharing, perinatally from infected mothers, and by use of unscreened blood or blood products, although no cases of transfusion transmitted HIV-2 have been reported in the United States. HIV-2 is present in close to 40 countries worldwide with the highest seroprevalence found in West Africa.

In 1987, the first case of HIV-2 infection in the U.S. was reported in a West African woman with symptoms of AIDS who was HIV-1 enzyme immunoassay (EIA) negative but indeterminate by HIV-1 Western Blot. Since that time, the CDC has documented 32 HIV-2 infections in the U.S. Of these 32 HIV-2 reports, 17 are from case surveillance and 15 are from serological surveys.(1) Five Massachusetts residents are included among the 17 AIDS/HIV case reports and three other Massachusetts residents HIV-2 infections were among the 15 reported from blinded serosurveys. Like the majority of cases in western countries, the U.S. cases have a West African tie either as country of origin or travel destination of infected individuals.

Methods to identify HIV-2 infected persons are similar to those available for the identification of HIV-1. Antibody to HIV-2 can be detected in serum by EIA, Western Blot (WB), peptide EIAs, radioimmunoprecipitation assay (RIPA) and polymerase chain reaction (PCR). The peptide-based immunoassays utilize synthetic peptides representing specific regions of HIV-1 and HIV-2. Licensed tests include an HIV-2 viral lysate EIA which detects antibodies to HIV-2 in serum or plasma and two combination or "combo" EIAs which are able to detect HIV-1 and HIV-2. Other essays available are for research use only and have not yet been licensed by the FDA.

Three basic strategies have been used in the Virology and Clinical Investigations Division at the State Laboratory of the Massachusetts Department of Public Health to find HIV-2 infected individuals. First, direct assessment of HIV-2 reactivity was carried out in large numbers of samples from groups at risk of HIV infection. These studies have included participation in a CDC multi-city study in which no HIV-2 positives were found. Massachusetts provided 1200 coded samples of more than 5000 samples tested. An additional 6,000 samples from the Massachusetts blinded seroprevalence studies (subject of recent newsletters) have also been tested directly for HIV-2. One positive specimen was found in a sexually transmitted disease clinic patient. Currently, direct HIV-2 assessment of clinical specimens is also offered for persons from West Africa or their sexual partners, if an HIV test is indicated.

A second strategy has been follow-up testing of HIV-1 indeterminate samples found at the State Laboratory. This has yielded three additional HIV-2 antibody specific specimens. HIV-1 and HIV-2 differ most in the part of the viral genome encoding the surface glycoproteins. Therefore, indeterminate HIV-1 Western Blot patterns lacking antibody to the surface glycoproteins are of particular importance for follow-up.

Lastly, providing HIV-2 testing for symptomatic HIV-1 negative patients and potentially infected family members has identified two additional HIV-2 antibody positives.

Inside:

- *Monthly Update....page 3*
- *Calendar..........page 4*

Next Month:
- *Resistant Tuberculosis*

For case reporting of AIDS patients meeting the CDC definition, please notify AIDS Epidemiologists at (617)522-3700, ext. 482 or 478.

Figure 1 – Confirmation Algorithm without a Licensed HIV-2 Western Blot Kit

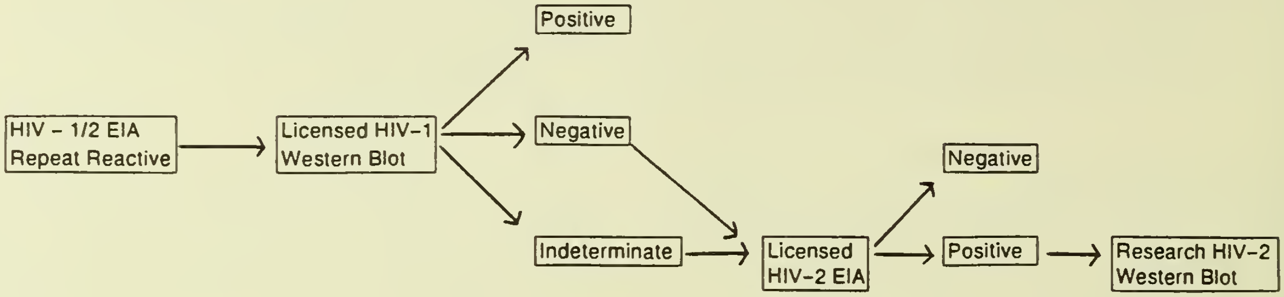
HIV – 1/2 EIA Repeat Reactive
Licensed HIV-1 Western Blot
Positive
Negative
Indeterminate
Licensed HIV-2 EIA
Negative
Positive
Research HIV-2 Western Blot

Figure 1 shows the testing algorithm recommended at the 6th Retroviral Consensus Conference of Association of State and Territorial Public Health Laboratory Directors for users of the HIV 1/2 combination assay. Note that the samples which are HIV-1 Western Blot negative or indeterminate will automatically be tested by an HIV-2 specific EIA to determine whether or not antibody to HIV-2 was responsible for the initial EIA reactivity. In situations where HIV-2 is highly suspect, HIV-1 Western Blot positive samples might also be tested to determine whether either co-infection or an exceptionally high degree of cross reactivity were occurring.

HIV 1/2 combination tests are now used by blood banks to screen directly for HIV-2, since HIV-1-only antibody tests detect some but not all HIV-2 antibody positive samples. More general use of the test for counseling and testing clients and for diagnostic evaluation will occur in the future. General use of the test for screening is not indicated at present since in most areas of the country no HIV-2 has been found and the prevalence of HIV-1 itself is low.

In conclusion, HIV-2 is similar to HIV-1 but is a distinctly identifiable virus. The modes of transmission are the same and infection with either is associated with the subsequent development of AIDS. Although the number of documented infections continues to increase, the prevalence of HIV-2 in the U.S. remains very low. The Massachusetts State Laboratory will continue to provide HIV-2 antibody testing on a case by case basis until the new algorithm using an HIV 1/2 combination EIA is implemented.

References: 1. O'Brien, T., George, R., and Holmberg, S. Human Immunodeficiency Virus Type 2 Infection in the United States JAMA, 1992, 267:2775-2779

AIDS Rates/100,000 by Metro Area

Boston	108
New Bedford	88
Brockton	80
Springfield	62
Worcester	46
Lawrence	42
Lowell	40
Fitchburg	38
Fall River	30

****

Notice to Readers: The July and August issues of the AIDS Newsletter will be combined into one issue to be distributed in August, 1992.

****

AIDS SURVEILLANCE SUMMARY

	Boston		Massachusetts		United States*	
Total Cases reported as of 6/1/92	1,896		5,015		218,301	
	No.	%	No.	%		
Residence						
City of Boston	1,896		1,896	38%		
Remainder of Boston SMSA**			1,201	24%		
Remainder of Massachusetts			1,613	32%		
Subtotal	1,896		4,710	94%		
Out-Of-State			305	6%		
Transmission Mode (Adult)	1,863		4,907		214,609	
Homosexual/Bisexual Male	1,141	61%	2,747	56%	124,961	58%
I.V. Drug User	360	19%	1,154	24%	48,312	23%
Homosexual I.V. Drug User	67	4%	205	4%	13,823	6%
Hemophiliac	8	0%	64	1%	1,812	1%
Heterosexual	208	11%	459	9%	12,881	6%
Blood Transfusion Recipients	18	1%	114	2%	4,537	2%
Undetermined	61	3%	164	3%	8,283	4%
Transmission Mode (Pediatric)	33		108		3,692	
Mother with AIDS/at risk for HIV	30	91%	93	86%	3,133	85%
Hemophiliac	1	3%	6	6%	173	5%
Blood Transfusion Recipient	2	6%	9	8%	296	8%
Undetermined	0	0%	0	0%	90	2%
Gender						
Male	1,674	88%	4,370	87%	193,994	89%
Female	222	12%	645	13%	24,307	11%
Mortality Status						
Alive	651	34%	1,806	36%	77,078	35%
Dead	1,245	66%	3,209	64%	141,223	65%
Race/Ethnicity						
White	1,118	59%	3,369	67%	116,542	53%
Black	617	33%	1,024	20%	63,941	29%
Hispanic	147	8%	581	12%	35,582	16%
Other/Unknown	14	1%	41	1%	2,236	1%
Age Group (years)						
Under 13	33	2%	108	2%	3,692	2%
13 - 19	1	0%	16	0%	821	0%
20 -29	359	19%	994	20%	42,462	19%
30 - 39	990	52%	2,474	49%	100,219	46%
40 - 49	394	21%	1,048	21%	48,889	22%
Over 49	119	6%	375	7%	22,218	10%

* Total Cases reported as of April 1, 1992

** Refers to the Boston Standard Metropolitan Statistical Area

UPDATE:

In May, fifty AIDS cases were reported to the AIDS Surveillance Program.

CALENDAR

"Women and HIV: Clinical Issues" Statewide HIV/AIDS Educational Series. June 25, State Laboratory, Jamaica Plain. For more information call Christie Burke at (617) 727-0368.

Meeting Change Boston University held three session information and support group for asymptomatic HIV+ to be moved to the Fenway Community Health Center on the first three Wednesdays of each month from 7-9 p.m. beginning in June. Participants must begin three session program on the first Wednesday or wait for the next month's series. Meetings are free and no registration necessary. For more information please call Robb Johnson at 267-0900 X287.

Weekly Support Group for HIV+ Women Monday support group for HIV+ women recovering from drug and alcohol addiction. No fee required. Please contact Magdaor Christine of Women, Inc. at (617) 442-6166.

"Tuberculosis and the HIV Connection" The Boston Department of Health and Hospitals offers a TB Seminar at your health care facility with CEU's. For more information please call David DeBiasi at (617) 534-5916.

Positive Directions Peer Support Line HIV+ and need someone to talk to? Please call (617) 247-7337 to talk or find out about support groups.

Spanish/English AIDS Hotline Individuals with HIV/AIDS looking for help should call(800) 637-3776.

Job Announcement:
Interim Project Director The National Coalition of Advocates for Students is looking for someone with experience administering a large federally funded project. The applicant should also have understanding of HIV issues and adolescents. The position will last for one year beginning late summer. Qualified applicants should call Devon Davidson at (617) 357-8507.

To have an announcement listed in the AIDS Newsletter Calendar, call (617) 522-3700, extension 478 or 482.

AIDS NEWSLETTER
is a publication of the
AIDS Surveillance Program

June 1992
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AIDS NEWSLETTER

Vol. 8 No. 7/8 Monthly Publication of the Massachusetts Department of Public Health July/August, 1992

MULTIDRUG RESISTANT TUBERCULOSIS AND HIV INFECTION

Tuberculosis (TB) case rates declined progressively for many years in the United States, but since the mid 1980's, the disease has presented a new face. This new face is characterized by an increasing number of cases. Tuberculosis cases increased nationally by over 14% in two years (22,436 cases in 1988 to 25,701 in 1990). Based on the downward trends of the previous 30 years, U.S. Centers for Disease Control (CDC) estimates that 25,000 excess cases have occurred between 1985 and 1990. In Massachusetts, this same trend has been noted.

An Interaction Between TB, HIV, Adverse Social Circumstances - Homelessness and Poverty

The national TB case rate has always obscured great variation from region to region in the United States. Large cities report rates of more than twice that of the nation as a whole, and districts within those cities often report case rates as high as those of many decades earlier. Although anyone can be infected with TB and develop active disease, those at the highest risk for TB consistently have been persons at the lowest socioeconomic level, recent arrivals from countries where TB is endemic, the elderly, alcoholics, and users of shelters, prisons and long term care institutions. Health care workers and other institutional workers caring for high risk persons have traditionally shared that risk.

Inside:

- *Monthly Update....page 3*
- *Calendar............page 4*

Next Month:

- **AIDS Survival Update**

Traditional risk groups have contributed to the present resurgence of TB. However, HIV co-infection is the single most potent factor in progression from TB infection to active TB disease. Rather than the usual 5-10% lifetime risk of progression to disease, HIV-infected persons have a 5-10% annual risk of progression. In crowded buildings with conditions favorable to airborne transmission, such as jails, prisons and shelters for the homeless, TB has been propagated at a rate unprecedented in U.S. history. In New York City, the rapidity with which TB has been acquired, transmitted, and transmitted again among high risk persons in shelters, prisons and health care facilities is compounded by late TB diagnosis, unavailability of drug susceptibility testing, and inadequate public health resources.

Increasing Development of Drug Resistance

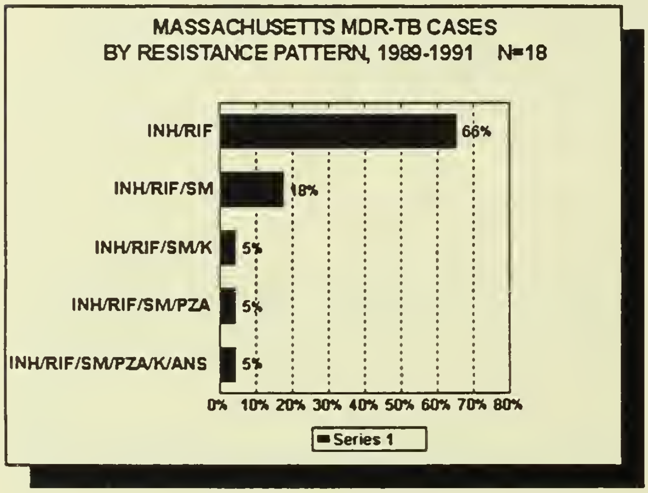
Resistance to TB drugs occurs in two settings. Primary resistance occurs when infection is due to a drug resistant organism. That is, drug resistant disease develops in a susceptible person. Secondary (or acquired) resistance is when a person initially presents *with drug sensitive TB* and then develops drug resistance. This is usually due to inappropriate treatment or poor compliance with treatment.

Systematic, nationwide collection of drug resistance testing data has been reinstated by CDC. An April, 1991 survey indicated that 33% (153/466) of the culture positive TB cases in New York City were resistant to at least one TB drug. As a point of reference, Massachusetts has had three drug resistant cases during the first quarter of 1991. CDC has defined multiple drug resistant tuberculosis (MDRTB) as involving an organism resistant to AT LEAST Isoniazid (INH)and Rifampin (RIF) - the two major drugs used in TB treatment.

Massachusetts has collected drug resistance data for several years. For the years 1989-1991, MDRTB

For case reporting of AIDS patients meeting the CDC definition, please notify AIDS Epidemiologists at (617)522-3700, ext. 482 or 478.

accounted for only 13% (18/141) of the total number of drug resistant cases reported (INH resistance alone being the primary resistance pattern noted in Massachusetts). Of the 18 MDRTB cases, 12 were reported as having resistance to only INH and RIF, three had three drug resistance, two had five drug resistance and one isolate was resistant to six anti-TB medications. Persons at high risk for developing MDRTB include: those who have been exposed to someone with MDRTB (especially if they are immunocompromised); TB patients who have failed to take medications as prescribed; and TB patients who have received suboptimal treatment.



Treatment of MDRTB involves two or more drugs to which the TB isolate is susceptible if taken for a period of 18 to 24 months. Because this treatment requires using less effective, more toxic second line drugs, direct supervision of the patient is desirable to ensure completion of therapy. If MDRTB is recognized quickly and the number of drugs prescribed is adequate, treatment should be effective.

Although there has been considerable press attention to drug resistant TB, MDRTB is not a 'NEW STRAIN' of tuberculosis. Drug resistance has been noted as long as there have been drugs to treat this disease and multidrug resistant TB has occurred in individual patients in the past. What is new is the occurrence of the outbreaks of MDRTB in HIV-infected persons.

Outbreaks of MDRTB in Institutional Settings

There have been recent reports of MDRTB outbreaks in hospitals in Florida and New York (1988 to the present), the New York correctional system (1991), a Michigan substance abuse treatment center (1989) and clusters in Mississippi and Missouri. The hospital outbreaks have involved nosocomial transmission of MDRTB to both patients and health care workers in these facilities. In the first four reported hospital outbreaks, 95% of patients with TB were HIV positive. Of those patients, 82% proceeded rapidly to death (median interval from TB diagnosis to death was an average of 8 weeks). TB conversion rates among health care workers (HCWs) have been very high and at least 8 HCWs have developed active MDRTB - 4 of whom have died (all were HIV infected).

In New York State, spread of MDRTB has been documented between hospitals and prisons across the state. At least 7 inmates have been diagnosed with MDRTB. Many factors contributed to the occurrence and propagation of these outbreaks. They include: the convergence of highly susceptible, immunocompromised patients and patients with TB; a delayed recognition of TB (diagnostic and laboratory); delayed recognition of drug resistance; delayed initiation of effective anti-TB treatment (patients remained infectious), and inadequate infection control procedures.

In Massachusetts, although factors are present that favor MDRTB outbreaks in health care and other high risk settings (such as the increasing incidence of TB and high prevalence of HIV), current and planned efforts to address drug resistance make it less likely that we will struggle with a problem of the magnitude of New York City's. Among these are the existence of the State Mycobacteriology Laboratory, the main reference laboratory for TB cultures in Massachusetts, where TB cultures are routinely tested for drug susceptibility, as well as a recently funded MDRTB Initiative to provide educational services to at-risk heath care facilities and case management for all MDRTB cases.

Increased vigilance by all health care providers will be needed in order to avoid the spectre of MDRTB. A high clinical index of suspicion for TB must be maintained so that patients with active TB can be identified early, appropriately managed and effectively treated. Persons exposed to TB need prompt evaluation and follow-up for preventive therapy. Health care workers in high risk settings need routine, periodic TB screening. Adequate isolation procedures need to be maintained. All persons with HIV infection should be skin tested for tuberculosis and prescribed preventive therapy, if positive. efforts must be made to ensure that all TB cases complete an adequate course of therapy.

Reference: Centers for Disease Control, "Guidelines for preventing the Transmission of Tuberculosis in Health Care settings, with Special Focus on HIV related Issues"; MMWR, 39 (RR-17).

AIDS SURVEILLANCE SUMMARY

	Boston		Massachusetts		United States*	
Total Cases reported as of 7/1/92	1,912		5,075		218,301	
	No.	%	No.	%		
Residence						
City of Boston	1,912		1,912	38%		
Remainder of Boston SMSA**			1,219	24%		
Remainder of Massachusetts			1,639	32%		
Subtotal	1,912		4,770	94%		
Out-Of-State			305	6%		
Transmission Mode (Adult)	1,878		4,966		214,609	
Homosexual/Bisexual Male	1,147	61%	2,764	56%	124,961	58%
I.V. Drug User	364	19%	1,176	24%	48,312	23%
Homosexual I.V. Drug User	67	4%	206	4%	13,823	6%
Hemophiliac	8	0%	64	1%	1,812	1%
Heterosexual	211	11%	470	9%	12,881	6%
Blood Transfusion Recipients	19	1%	117	2%	4,537	2%
Undetermined	62	3%	169	3%	8,283	4%
Transmission Mode (Pediatric)	34		109		3,692	
Mother with AIDS/at risk for HIV	31	91%	94	86%	3,133	85%
Hemophiliac	1	3%	6	6%	173	5%
Blood Transfusion Recipient	2	6%	9	8%	296	8%
Undetermined	0	0%	0	0%	90	2%
Gender						
Male	1,690	88%	4,416	87%	193,994	89%
Female	222	12%	659	13%	24,307	11%
Mortality Status						
Alive	633	33%	1,798	35%	77,078	35%
Dead	1,279	67%	3,277	65%	141,223	65%
Race/Ethnicity						
White	1,127	59%	3,400	67%	116,542	53%
Black	622	33%	1,041	21%	63,941	29%
Hispanic	149	8%	593	12%	35,582	16%
Other/Unknown	14	1%	41	1%	2,236	1%
Age Group (years)						
Under 13	34	2%	109	2%	3,692	2%
13 - 19	1	0%	16	0%	821	0%
20 -29	360	19%	1,003	20%	42,462	19%
30 - 39	998	52%	2,506	49%	100,219	46%
40 - 49	400	21%	1,062	21%	48,889	22%
Over 49	119	6%	379	7%	22,218	10%

* Total Cases reported as of April 1, 1992

** Refers to the Boston Standard Metropolitan Statistical Area

UPDATE:

In June, sixty AIDS cases were reported to the AIDS Surveillance Program.

CALENDAR

Asymptomatic HIV+ Support Group. Fenway Community Health Center. First three Wednesdays of each month from 7-9 p.m. Sessions begin on the first Wednesday of month. Meetings are free. For more information please call Robb Johnson at (617) 267-0900 X287.

Weekly Support Group for HIV+ Women. Monday support group for HIV+ women recovering from drug and alcohol addiction. No fee. Please contact Magdaor Christine of Women, Inc. at (617) 442-6166.

"Tuberculosis and the HIV Connection". The Boston Department of Health and Hospitals offers a TB Seminar at your health care facility with CEU's. For more information please call David DeBiasi at (617) 534-5916.

Spanish/English AIDS Hotline. Individuals with HIV/AIDS looking for help should call (800) 637-3776.

HIV Pre and Post Test Counseling and Testing and Seropositive Issues Training. October 28, 29, 30, and November 2, 3, 1992, State Labs, Jamaica Plain, Call (617) 727-0368 for an application.

"Positive Directions" will hold a Gay discordant group for couples. 2nd and 4th Tuesday each month, at the Boston Living Center. Any questions, please call Will Escorbar at 262-3456. Also Peer Support Line, please call (617) 247-7337 to talk or for info.

MPHA Conference for Health Care Workers Infected and Affected. October 28, 1992, 8:30 A.M. to 1:30 P.M. Federal Reserve Bank. The Conference will present newly developed MA state plan for managing infected health care workers. Any questions please call Donna French at (617) 727-0732.

Job Announcement. R.N. Case Manager position available for V.N.A. of Greater Lynn. Send resume to Chris Guercio, 16 City Hall Square, Lynn, MA 01901. For information call (617) 598-2454.

Support Group for AIDS Caregivers. Packard-Manse Brockton V.N.A. Call Kim Jordan at (508) 587-2121.

To have an announcement listed in the AIDS Newsletter Calendar, call (617) 522-3700, extension 478 or 482.

AIDS NEWSLETTER
is a publication of the
AIDS Surveillance Program

July/August 1992

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AIDS NEWSLETTER

Vol. 8 No. 9 Monthly Publication of the Massachusetts Department of Public Health September, 1992

IDIOPATHIC CD4-LYMPHOCYTOPENIA: WHAT IS IT?

During the recent VIIIth International Conference on AIDS held in Amsterdam, attention was drawn to individuals with persistently low CD4 lymphocyte counts with no evidence of HIV infection. In response to concern in the scientific and public health communities about these cases, a meeting was convened at the Centers for Disease Control (CDC) on August 4, 1992. Several hundred investigators from throughout the world attended this one-day meeting to report on patients with this condition and the results of laboratory investigations. A total of 26 cases of this new syndrome, named Idiopathic CD4-Lymphocytopenia (ICL), were reported from seven countries (Australia, Denmark, England, France, Germany, Spain, and the United States).

Since then the cumulative total reported in the United States has been 47, with an additional 11 cases reported in other countries. Massachusetts is currently investigating reports of several possible ICL cases, with two possibly meeting the case definition (see Table 1). A summary of clinical information from the cases of ICL reveals that some but not all of these cases had/have clinical conditions that are currently included in the AIDS case definition (i.e. *Mycobacterium avium* infection, *Pneumocystis carinii* pneumonia). Although an epidemiologic investigation of these cases has been initiated by the CDC, common links between cases have yet to be established.

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Inside:

- *Monthly Update*....*page 3*
- *Calendar*.............*page 4*

Next Month:

- **New England AIDS Update**

It is unclear whether the reported cases of ICL are the result of HIV infection, a new retrovirus or another agent (preliminary studies suggest the presence of retroviral activity in some of the individuals) or due to many different causes. The widespread use of T-lymphocyte immunotyping in the wake of the HIV and AIDS epidemic may have brought cases of sporadic immunosuppression to laboratory recognition.

For the purpose of surveillance of possible cases of ICL, the CDC has devised a case definition. Individuals with low CD4 cell counts and no evidence of either HIV infection or other identifiable reason for immunosuppression meet this definition. Table 1 outlines the clinical and laboratory criteria needed to meet the ICL case definition.

The CDC has also established a protocol to collect information on ICL cases to assist in determining the precision of the above case definition and to study the epidemiology and etiology of these cases. Information on risk behaviors, receipt of blood products, clinical conditions, and laboratory findings (i.e. results of HIV tests and CD4 Lymphocyte counts) along with base demographic information will be collected for all suspect cases of ICL.

For case reporting of AIDS patients meeting the CDC definition, please notify AIDS Epidemiologists at (617)522-3700, ext. 482 or 478.

Any Massachusetts health care provider who knows of persons meeting the ICL case definition may contact the Massachusetts AIDS Surveillance Program at (617) 522-3700, extension 487. Case report forms for ICL can also be obtained by calling this number. Information will be forwarded, without personal identifiers, to the CDC. Further epidemiologic investigation of these cases may be conducted jointly by the CDC and the Massachusetts Department of Public Health through the cooperation of the health care provider and the consent of the patient. Priority for follow-up will be given to persons who are living, transfusion recipients, and person with known sexual partners.

Table 1.

CDC Case Definition for Idiopathic CD4-T-Lymphocytopenia

***CD4 lymphocyte count <300 cells/mm3 or <20% on more than one determination**

***No serological evidence of HIV**

***No defined immunodeficiency or therapy associated w/depressed CD4+ T cell levels**

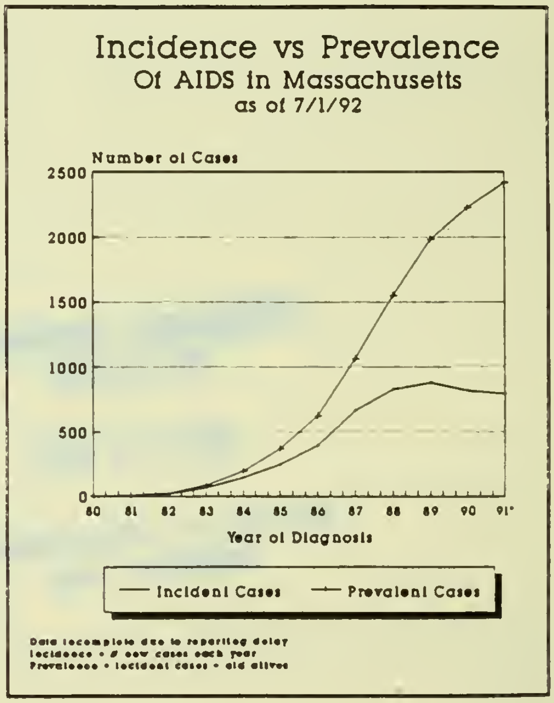
In addition, providers may consider referring patients meeting the case definition outlined in Table 1 to the National Institutes of Health (NIH) for further evaluation. These patients will receive extensive immunologic and virologic evaluations that will be shared with the referring physician and the primary care provider. All travel and costs associated with this evaluation will be paid by the NIH. Health care providers wishing to receive more information about this option should call the NIH at (800) AIDS-NIH.

* *

Update on AIDS Case Definition

* *

In November of 1991, the CDC published a revised classification system for HIV infection and proposed the expansion of the adult AIDS surveillance case definition to include HIV infected persons with CD4-lymphocyte counts < 200/mm3. This expanded case definition was originally slated to go into effect in April of 1992. However, concerns that this definition would seriously undercount the number of women and drug users with AIDS have led to further discussions by public health officials and resulted in the delay of the definition's implementation. In a September 2, 1992 meeting held at the CDC, a counter proposal by AIDS advocates suggested that pulmonary tuberculosis, cervical cancer/dysplasia and recurrent bacterial pneumonias also be added to the current list of 23 "AIDS defining" conditions. The CDC is accepting public comment about the AIDS case definition through September 18, 1992. A decision about the content of the case definition and its date of implementation is expected shortly after that date.



For case reporting of AIDS patients meeting the CDC definition, please notify AIDS Epidemiologists at (617)522-3700, ext. 482 or 478.

AIDS SURVEILLANCE SUMMARY

	Boston		Massachusetts		United States*	
Total Cases reported as of 9/1/92	1,951		5,223		230,179	
	No.	%	No.	%		
Residence						
City of Boston	1,951		1,951	37%		
Remainder of Boston SMSA**			1,255	24%		
Remainder of Massachusetts			1,712	33%		
Subtotal	1,951		4,918	94%		
Out-Of-State			305	6%		
Transmission Mode (Adult)	1,917		5,114		226,281	
Homosexual/Bisexual Male	1,162	61%	2,819	55%	130,822	58%
I.V. Drug User	378	20%	1,231	24%	51,477	23%
Homosexual I.V. Drug User	67	3%	211	4%	14,487	6%
Hemophiliac	8	0%	66	1%	1,875	1%
Heterosexual	217	11%	485	9%	14,045	6%
Blood Transfusion Recipients	19	1%	120	2%	4,659	2%
Undetermined	66	3%	182	4%	8,916	4%
Transmission Mode (Pediatric)	34		109		3,898	
Mother with AIDS/at risk for HIV	31	91%	94	86%	3,315	85%
Hemophiliac	1	3%	6	6%	179	5%
Blood Transfusion Recipient	2	6%	9	8%	300	8%
Undetermined	0	0%	0	0%	104	3%
Gender						
Male	1,720	88%	4,542	87%	204,038	89%
Female	231	12%	681	13%	26,141	11%
Mortality Status						
Alive	655	34%	1,844	35%	78,026	34%
Dead	1,296	66%	3,379	65%	152,153	66%
Race/Ethnicity						
White	1,144	59%	3,492	67%	121,762	53%
Black	636	33%	1,068	20%	67,972	30%
Hispanic	157	8%	621	12%	38,113	17%
Other/Unknown	14	1%	42	1%	2,332	1%
Age Group (years)						
Under 13	34	2%	109	2%	3,898	2%
13 - 19	1	0%	16	0%	872	0%
20 -29	368	19%	1,036	20%	44,495	19%
30 - 39	1,015	52%	2,572	49%	105,522	46%
40 - 49	413	21%	1,100	21%	51,921	23%
Over 49	120	6%	390	7%	23,471	10%

* Total Cases reported as of July 1, 1992

** Refers to the Boston Standard Metropolitan Statistical Area

UPDATE:

In August, ninety AIDS cases were reported to the AIDS Surveillance Program.

CALENDAR

Asymptomatic HIV+ Support Group. To be held at the Fenway Community Health Center on the first three Wednesdays of every month from 7-9 p.m. month. (617) 267-0900 X287

Weekly Support Group for HIV+ Women. Women Inc. sponsors a Monday evening support group for HIV+ women recovering from drug and alcohol addiction. (617) 442-6166

HIV Pre and Post Test Counseling and Testing and Seropositive Issues Training. October 28, 29, 30, and November 2, 3, 1992 at the State lab, Jamaica Plain. Call (617) 727-0368 for an application.

"New" Tubercolisis: Today's Medical, Scientific, Epidemiological and Public Health Issues The 5th annual Ted Badger TB conference is offered for health care officials on 12/8-12/9 at the Sheraton Tara in Framingham. CME's and CEU's are offered. (617) 522-3700 X450

"Positive Directions" will hold a support group for gay couples of mixed HIV status on the 1st and 3rd Monday of each month at the Boston Living Center. (617) 262-3456. The BLC also sponsors a peer support line, (617) 247-7337.

MPHA Conference for Health Care Workers Infected and Affected. The conference will present newly developed state plan for managing infected health care workers at the Federal Reserve Bank. October 28, 1992, 8:30 a.m. to 1:30 p.m. (617) 727-0732.

HIV+ Educational/Support Group Individuals are encouraged to invite a family member or a friend. Childcare will be provided. First Wednesday of the month for three weeks, 5:00 - 6:30 p.m.. A free home-cooked meal will be provided. (617) 288-3230 X278.

Does someone you love have HIV? The Neponset Health Center offers a Wednesday evening support group for the friends, family and significant others of people with HIV infection. (617) 282-3200.

Weekly Spiritual Support Group The Boston Catholic Archdiocese offers this free Tuesday support group at 7:30 p.m.. for PWAs, HIV+ individuals and their caregivers. (617) 482-5440.

Professional AIDS Care Givers Support Group meets bimonthly on the 2nd and 4th Wednesday, 5-7 p.m. at the Brockton VNA. (508) 587-2121

AIDS NEWSLETTER
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AIDS NEWSLETTER

Vol. 8 No. 10 Monthly Publication of the Massachusetts Department of Public Health October, 1992

UPDATE: AIDS in New England

The second decade of the AIDS epidemic is underway and the epidemiology of the epidemic is beginning to change. In urban areas, cases are occurring increasingly in injection drug users (IDU), women and people of color. The residence of AIDS cases is shifting from urban areas to suburban and rural areas.

Since not all the New England states report HIV infection, (NH, ME and RI each report HIV anonymously, CT reports pediatric HIV infection by name, and MA and VT have no reporting of HIV) this article will focus on statistics concerning full-blown CDC-defined AIDS, which is reportable in all states. It is important to remember that these numbers look only at one segment of the HIV epidemic and not the entire human toll of HIV infection.

As of September 1, 1992, 9,242 cases were reported in the six New England States. Of these, 1,598 cases were reported in the year from July 1, 1991 through June 30, 1992. The New England region accounts for four percent of cumulative U.S AIDS cases. Five percent of the U.S. population lives in New England. The cumulative case rate for New England is 65 AIDS cases per 100,000 population. This compares to the national case rate of 93 per 100,000 population (1). Massachusetts continues to report the greatest number of cases in New England with 5,223 reported since the early 1980's. Connecticut has the highest cumulative case rate of the New England states with 80 cases per 100,000 population. Among the six states Vermont has both the fewest reported cases, 115 as of September 1, 1992 and the lowest case rate, 19 cases per 100,000 population.

Among New England's cities, Boston, with the regions largest population, has the greatest number of cases with 1,951. The Connecticut cities of New Haven, Hartford, and Bridgeport have 573, 508, and 293 cases, respectively. Providence, Rhode Island is next with 242 cases followed by the Massachusetts cities of Springfield and Worcester with 227 and 152, respectively.

Inside:

- *Monthly Update....page 3*
- *Calendar............page 4*

Next Month:

- **AIDS Survival in Massachusetts**

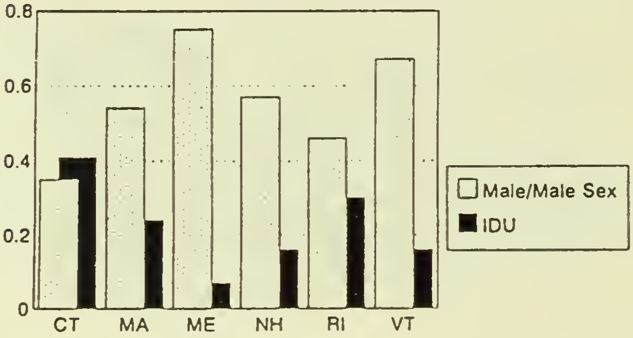
Table I Cumulative and Recent AIDS Cases and Rates by State

	Total Cases	Rate per 100,000
CT	2,768	80
MA	5,223	79
ME	307	24
NH	272	24
RI	557	53
VT	115	19
N.E.	1,598	65
U.S.*	230,179	93

As Table I shows, the majority of New England cases (7,991/9,242) are from Connecticut and Massachusetts. This is not surprising given the high percentage of New England's population that lives in these two states, and the presence of larger urban centers.

The AIDS epidemic in each of these states is different. Connecticut's epidemic is dominated by injection drug use (IDU) related cases which represent 42% of total AIDS cases. Massachusetts' epidemic, though changing, is still dominated by male/male sex as a risk behavior with 55% of total cases. The epidemiology of Rhode Island's cases demonstrates elements of Connecticut and Massachusetts with 30 percent of cases being related to IDU and 55 percent being related to male/male sex.

Figure 1 New England AIDS Cases Risk Factors by State



*Risks include pediatric, transfusion, hemophiliac and unidentified risk cases.

In the entire United States the epidemic is similar to that in Massachusetts where the ratio of male/male transmission is more than twice that of IDU related transmission. However, recent cases show an increase in IDU related cases relative to male/male sex related cases. Six of nine metropolitan areas in Massachusetts have reported more IDU related cases than male/male sex related cases. The New Bedford area reports more than two IDU related cases for every male/male sex related case. AIDS cases documented in NH, VT, and ME, follow the national pattern where male/male sex related cases still far outnumber those of any other risk category.

Table 2 selected Demographics of AIDS Cases in the New England States

	CT	*MA*	*ME*	*NH*	*RI*	*VT*
Sex:						
Male	80%	87%	94%	88%	85%	91%
Female	20%	13%	6%	12%	15%	9%
Race:						
White	43%	67%	95%	91%	68%	NA
Black	39%	20%	3%	5%	21%	NA
Latino	18%	12%	1%	4%	10%	NA
Other	0%	1%	1%	0%	0%	NA
Age:						
<13	2%	2%	0%	2%	1%	2%
13-19	0%	0%	0%	1%	0%	2%
20-29	19%	20%	26%	23%	23%	17%
30-39	46%	49%	42%	45%	47%	45%
40-49	22%	21%	21%	17%	21%	26%
>50	11%	7%	10%	11%	7%	8%
Data as of 9/1/92						

Reflecting the role of injection drug use, in Connecticut the proportion of cases in women and in children under age 13 years is greater than in the other New England states or the United States. In Connecticut, 20 percent of cases are in women and 81 of 2,768 cases are in individuals thirteen years of age or younger. In Massachusetts despite the much higher case numbers (5,223) proportionally fewer numbers of pediatric cases have been reported (109).

The Northern New England states (Maine, New Hampshire and Vermont), continue to see a slow but steady rise in IDU related AIDS cases, especially in urban areas. In addition, AIDS cases are beginning to appear in the more rural regions of Northern New England. Overall, the epidemiology reflects that of Massachusetts several years earlier, one which is dominated by male/male related cases but beginning to move into other populations.

(1) New England statistics are available as of 9/92, U.S. statistics are available as of 7/92

For case reporting of AIDS patients meeting the CDC definition, please notify AIDS Epidemiologists at (617)522-3700, ext. 482 or 478.

AIDS SURVEILLANCE SUMMARY

	Boston		Massachusetts		United States*	
Total Cases reported as of 10/1/92	1,979		5,307		230,179	
	No.	%	No.	%	No.	%
Residence						
City of Boston	1,979		1,979	37%		
Remainder of Boston SMSA*			1,279	24%		
Remainder of Massachusetts			1,740	33%		
SubTotal	1,979		4,998	94%		
Out of State Residence			309	6%		
Transmission Mode (Adults)	1,945		5,195		226,281	
Homosexual/Bisexual Male	1,182	61%	2,859	55%	130,822	58%
I. V. Drug User	383	20%	1,253	24%	51,477	23%
Homosexual IV Drug Users	67	3%	217	4%	14,487	6%
Hemophiliac	8	0%	67	1%	1,875	1%
Heterosexual	218	11%	490	9%	14,045	6%
Blood Transfusion Recipient	19	1%	123	2%	4,659	2%
Undetermined	68	3%	186	4%	8,916	4%
Transmission Mode (Pediatric)	34		112		3,898	
Mother with AIDS/at risk for HIV	31	91%	97	87%	3,315	85%
Hemophiliac	1	3%	6	5%	179	5%
Blood Transfusion Recipient	2	6%	9	8%	300	8%
Undetermined	0	0%	0	0%	104	3%
Gender						
Male	1,746	88%	4,609	87%	204,038	89%
Female	233	12%	698	13%	26,141	11%
Mortality Status						
Alive	676	34%	1,885	36%	78,026	34%
Dead	1,303	66%	3,422	64%	152,153	66%
Race/Ethnicity						
White	1,163	59%	3,551	67%	121,762	53%
Black	644	33%	1,086	20%	67,972	30%
Hispanic	158	8%	631	12%	38,113	17%
Other/Unknown	14	1%	39	1%	2,332	1%
Age Group (years)						
Under 13	34	2%	112	2%	3,898	2%
13 - 19	1	0%	17	0%	872	0%
20 - 29	370	19%	1,046	20%	44,495	19%
30 - 39	1,031	52%	2,609	49%	105,522	46%
40 - 49	419	21%	1,124	21%	51,921	23%
Over 49	124	6%	399	8%	23,471	10%

*Total Cases reported as of July 1, 1992

** Refers to the Boston Standard Metropolitan Statistical Area

UPDATE:

In September, 87 AIDS Cases were reported to the AIDS Surveillance Program

CALENDAR

HIV/AIDS Update Conference Massachusetts Hospital Association sponsored conference to be held 11/30 from 8:30 a.m. to 12:30 p.m.. For registration information call Sharon Larson at (617) 272-8000 X177.

HIV Case Management Training To be held 11/9-11/11 and 11/16-11/17 at the State Lab, Jamaica Plain. Call (617) 727-0368 for an application.

Asymptomatic HIV+ Support Group. To be held at the Fenway Community Health Center on the first three Wednesdays of every month from 7-9 p.m. (617) 267-0900 X287

Spanish/English AIDS Hotline. Individuals with HIV/AIDS looking for help should call (800) 637-3776.

"Positive Directions" will hold a support group for gay couples of mixed HIV status. Offered the 1st and 3rd Monday of each month at Positive Directions, for information call Will Escobar at (617) 262-3456. Positive Directions also sponsors a peer support line (617) 247-7337.

Support Group for Caregivers. To be held on the second and fourth Wednesday of each month at the Brockton V.N.A. for information call Kim Jordan at (508) 587-2121.

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Weekly Spiritual Support Group The Boston Catholic Archdiocese offers this free Tuesday support group at 7:30 p.m.. for PWAs/HIV+ individuals and their caregivers. Call (617) 482-5440.

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AIDS NEWSLETTER

Vol. 8 No. 11 Monthly Publication of the Massachusetts Department of Public Health November, 1992

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Survival with AIDS in Massachusetts

Advances in the treatment of HIV infection and prophylaxis against associated opportunistic infections have increased survival time for persons with AIDS. Published studies have estimated that the survival time of AIDS patients ranges from 7 months to 14.8 months. A recent study by Seage and colleagues has estimated that the median survival time for persons diagnosed with AIDS in Massachusetts between January 1, 1979 and December 31, 1988 was 406 days (13.5 months). In that study, survival time was shorter in older persons, people with a history of injecting drug use and AIDS-defining conditions other than Kaposi's sarcoma (KS). Other studies have shown that survival in AIDS patients may be associated with race, gender, risk, use of therapeutic agents, and clinical presentation.

Despite statistical predictions of survival, some persons with AIDS live much longer than expected. Much can be learned about prognostic indicators of survival time by studying the characteristics of these long term survivors of AIDS. In order to describe the epidemiologic characteristics of long-term survivors of AIDS in Massachusetts, the AIDS Surveillance Program performed a subanalysis of all 5072 adult Massachusetts residents reported with AIDS as of July 1, 1992.

Long term survivors were defined as those who had lived for at least 36 months from the date of initial AIDS diagnosis. Persons diagnosed with AIDS before July 1, 1988 without a documented date of death, were presumed to be alive on July 1, 1991 and were also considered to be long-term survivors. A cohort of short-term survivors, persons who had lived for less than 15 months from the date of their initial AIDS diagnosis, was selected for comparison. Two thousand eight hundred eighty-five persons whose survival time was between 15 and 35 months were excluded from our analysis.

Once these cohorts were identified, comparisons were made with regard to risk behaviors for HIV infection, demographic variables(i.e. sex, race, age, residence), clinical manifestations, and dates of AIDS diagnosis.

A total of 319 long term survivors and 1868 short-term survivors were identified. Median survival for short-term survivors was 4.4 months (range 0 to 15 months). This compares with a median 44.5 month survival in long term survivors (range 36 to 94 months).

Calculation of crude (unadjusted) odds ratios (OR) revealed that long-term survivors were more likely to have engaged in male/male sex than any other risk behavior (OR = 1.47, 95% Confidence Interval (CI) = 1.14, 1.88) and to have been a resident of the city of Boston at the time of their AIDS diagnosis (OR = 1.41, 95% CI = 1.10, 1.80). In addition, a inverse linear relationship was noted between long term survival and age (see Figure 1). Twenty-two percent of AIDS cases who were 13-19 years of age were long term survivors compared with only five percent of cases greater than 60 years of age.

Inside:

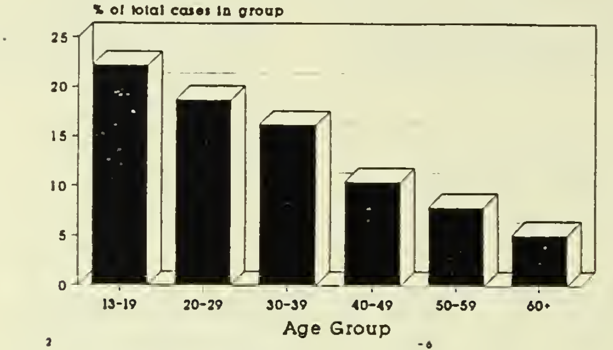
- **Monthly Update....page 3**
- **Calendar..........page 4**

Next Month:
- **HIV/HBV: Prevention Measures in the Health Care Setting**

For case reporting of AIDS patients meeting the CDC definition, please notify AIDS Epidemiologists at (617)522-3700, ext. 482 or 478.

Figure 1

LTS with AIDS in Massachusetts
By Age Group of Diagnosis



X^2 test for trend = 23.03, p = 1.2 x (10^{-6})

A linear trend also was noted between long term survival and more recent year of diagnosis. Eight percent of AIDS cases diagnosed in 1982 were long-term survivors; of cases diagnosed in 1988 26% were long-term survivors.

Table 1

Indicator Disease	# Cases Observed	# Cases Expected	Crude OR	95% CI's
C.M. Herpes	13	7	2.18	1.09,4.32
Kaposi's Sarcoma	71	44	1.94	1.44,2.61
Extra. Pulm. TB	16	11	2.25	1.20,4.17
Other	375	400	—	—

*Comparison group is all other diagnosis

As Table 1 demonstrates, long-term survivors also differed significantly from short-term survivors by clinical presentation. Long term survivors were more likely to have been reported with chronic mucocutaneous herpes (OR = 2.18, 95% CI = 1.09, 4.32), Kaposi's sarcoma (OR= 1.94, 95% CI = 1.44, 2.61), and extrapulmonary tuberculosis (OR=2.25, 95% CI = 1.20, 4.17).

After controlling for potential confounding with the use of a multiple logistic regression model, only the following were found to be significantly associated with long-term survival:

- decreasing age
- more recent year of AIDS diagnosis
- presence of Kaposi's Sarcoma, chronic mucocutaneous herpes, or extrapulmonary tuberculosis.

Risk behavior of patient and residence of patient at time of AIDS diagnosis was no longer associated with long term survival after controlling for confounding by other factors. Race and sex of the AIDS patient was not associated with survival in either the crude analysis or after adjusting for confounding.

As previously noted, increased survival with AIDS has been shown to be related to a variety of factors such as risk behavior, sex, clinical presentation, year of AIDS diagnosis, and use of antiviral medications. In this analysis, no information about the use of medications was available and therefore their effect on long term survival could not be evaluated. Further investigations to study the effect of treatments as well as patients' access to medical care must be conducted before conclusions can be drawn about additional predictors of long-term survival.

Massachusetts AIDS Cases by Metropolitan Area

SMSA	Rate* per 100,000
Boston	111.8
New Bedford	91.4
Brockton	83.7
Springfield	65.7
Worcester	46.9
Lawrence	44.2
Lowell	41.4
Fitchburg	38.8
Fall River	28.9

AIDS SURVEILLANCE SUMMARY

	Boston		Massachusetts		United States*	
Total Cases reported as of 11/1/92	2,000		5,384		242,146	
	No.	%	No.	%	No.	%
Residence						
City of Boston	2,000		2,000	38%		
Remainder of Boston SMSA*			1,299	24%		
Remainder of Massachusetts			1,775	33%		
SubTotal	2,000		5,074	96%		
Out of State Residence			310	6%		
Transmission Mode (Adults)	1,966		5,271		238,095	
Homosexual/Bisexual Male	1,193	61%	2,896	55%	136,912	58%
I. V. Drug User	390	20%	1,277	24%	54,475	23%
Homosexual IV Drug Users	67	3%	219	4%	15,203	6%
Hemophiliac	8	0%	68	1%	1,953	1%
Heterosexual	222	11%	500	9%	15,221	6%
Blood Transfusion Recipient	19	1%	123	2%	4,833	2%
Undetermined	67	3%	188	4%	9,498	4%
Transmission Mode (Pediatric)	34		113		4,051	
Mother with AIDS/at risk for HIV	31	91%	98	87%	3,480	86%
Hemophiliac	1	3%	6	5%	183	5%
Blood Transfusion Recipient	2	6%	9	8%	303	7%
Undetermined	0	0%	0	0%	85	2%
Gender						
Male	1,764	88%	4,677	87%	214,315	89%
Female	236	12%	707	13%	27,831	11%
Mortality Status						
Alive	690	35%	1,937	36%	81,774	34%
Dead	1,310	66%	3,447	64%	160,372	66%
Race/Ethnicity						
White	1,171	59%	3,599	67%	127,317	53%
Black	652	33%	1,102	20%	71,984	30%
Hispanic	163	8%	644	12%	40,353	17%
Other/Unknown	14	1%	39	1%	2,492	1%
Age Group (years)						
Under 13	34	2%	113	2%	4,051	2%
13 - 19	1	0%	17	0%	912	0%
20 - 29	371	19%	1,056	20%	46,476	19%
30 - 39	1,041	52%	2,646	49%	110,849	46%
40 - 49	425	21%	1,144	21%	55,038	23%
Over 49	128	6%	408	8%	24,820	10%

Total Cases reported as of July 1, 1992

* Refers to the Boston Standard Metropolitan Statistical Area

UPDATE:

n October, 77 AIDS Cases were reported to the AIDS Surveillance Program

CALENDAR

HIV/AIDS Update Conference Massachusetts Hospital Association sponsored conference to be held 11/30 from 8:30 a.m. to 12:30 p.m.. For registration information call Sharon Larson at (617) 272-8000 X177.

Asymptomatic HIV+ Support Group. To be held at the Fenway Community Health Center on the first three Wednesdays of every month from 7-9 p.m. (617) 267-0900 X287

Spanish/English AIDS Hotline. Individuals with HIV/AIDS looking for help should call (800) 637-3776.

"**Positive Directions**" will hold a support group for gay couples of mixed HIV status. Offered the 1st and 3rd Monday of each month at Positive Directions, for information call Will Escobar at (617) 262-3456. Positive Directions also sponsors a peer support line (617) 247-7337.

Support Group for Caregivers. To be held on the second and fourth Wednesday of each month at the Brockton V.N.A. for information call Kim Jordan at (508) 587-2121.

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AIDS NEWSLETTER
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AIDS Surveillance Program
November
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AIDS NEWSLETTER

Vol. 8 No. 12 Monthly Publication of the Massachusetts Department of Public Health December, 1992

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HIV/HBV in Health Care Settings

Events over the past several years of the human immunodeficiency virus (HIV) epidemic and concerns regarding the possible transmission of this and other infectious agents in health care settings have raised public health and safety issues. Of particular note was the case of a Florida dentist and the strong possibility that he transmitted the HIV virus to five of his patients.

In July of 1991, the federal Centers for Disease Control (CDC) issued guidelines for the prevention of HIV and Hepatitis B virus transmission to patients during exposure prone procedures. In October 1991, the U.S. Congress enacted legislation that required all states to certify implementation of these or equivalent guidelines or lose public health funding.

In response to the legal mandate and to concerns of both the public and health care workers (HCW), the Massachusetts Department of Public Health in October, 1992, released its ***"Recommendations and Action Plan to Prevent the Transmission of HIV and HBV in the Delivery of Health Care Services".***

In addition to Massachusetts, 21 other states have written recommendations that are equivalent to the Centers for Disease Control Guidelines (CDC). Massachusetts guidelines were developed by a committee comprised of public health and infection control experts, representatives of medical, dental and nursing associations, hospital/health care facility administrators, advocates, consumers and attorneys. The report is divided into two sections. The first deals with maximizing the implementation of universal blood and body fluid precautions. The second provides a mechanism to evaluate HIV-infected HCWs.

I. Strengthening Infection Control

Currently, all Massachusetts employers, except state and local governments, are required to implement the Occupational Health and Safety Administration (OSHA) Bloodborne Pathogen Standard. The report recommends the adoption of OSHA equivalent standards for public employees as well. Consequently, OSHA guidelines would be applicable to every worker in the state.

Employers would be responsible to do the following for all employees at risk:

- Supply all necessary equipment to fully accomplish universal precautions
- Establish employee trainings
- Develop a written exposure control plan
- Provide free Hepatitis B vaccine for all employees at risk.

Inside:

•Monthly Update....page 3
•Calendar..........page 4

Next Month:
Pediatric HIV and AIDS

To further ensure that the highest standard of infection control is in use in the state, the following specific recommendations were made:

- Public agencies should work with health care facilities and professional organizations to reinforce infection control and universal precautions principles.

- Public agencies should educate the public about the importance of infection control procedures and their implementation.

- Continuing education programs concerning infection control procedures should be developed.

- The Department of Public Health should organize a professional consortium to integrate infection control into the curricula of all medical, dental, nursing or allied health education programs.

- Insurance-based incentives should be created to encourage infection control training.

II. Evaluating HIV-Infected Health Care Workers

While transmission of HIV and HBV may occur either from patient-to-HCW or HCW-to-patient, to date there has been only one case of apparent infection from a HCW to patients. As a result of subsequent concerns about HIV transmission from the HIV-infected worker to patients, HIV antibody testing is strongly encouraged, though not required, for HCWs at risk of infection from personal behavior or occupational exposure. A policy of mandatory testing for all health care workers was considered, but such a policy could actually put the public at greater risk by ultimately imposing a false sense of security. Even an HIV-positive HCW, should pose no risk to patients as long as universal precautions are taken. For the HIV-positive HCW who seeks information and referral, the option of anonymity is important at the point of entry to services.

An expert DPH panel will be established to oversee a voluntary evaluation process for HIV or HBV infected HCWs. The deliberations of the panel would be conducted with strict confidentiality. Any restrictions placed on a HCWs' practice would be determined on a case-by-case basis taking into consideration the ability of the HCW to perform his/her job safely and effectively.

If recommendations regarding restrictions were disregarded by the HCW and, if this was deemed to place patients at risk, the panel may refer the HCW's situation to the appropriate board of registration for further action. Any necessary job reassignment should only occur under full consideration of all statutes protecting HIV-positive HCWs. In such an event, professional organizations would assist in any reassignment or retraining. In addition, health care facilities, professional associations and government agencies should work collaboratively to develop programs which provide opportunities for HIV infected HCWs to retain health care and disability insurance.

The recommendations in the report are intended not to recreate the functions of existing agencies but rather to assist and encourage them in their activities and assure that both the public and health care providers are fully informed of the elements of infection control and of the agencies and efforts that are in place. Copies of the "Recommendations and Action Plan to Prevent the Transmission of HIV and HBV in the Delivery of Health Care Services" are available from the HIV/AIDS Bureau either by calling or writing Mariette Guerra at the Bureau at (617) 727-0368, 150 Tremont St., Boston, MA 02111. HCWs who are either HIV-positive or at-risk may call Lisa Gurland, RN, Psy. D. at (617) 727-0368 for information regarding available support services.

AIDS SURVEILLANCE SUMMARY

	Boston		Massachusetts		United States*	
Total Cases reported as of 12/1/92	2,023		5,470		242,146	
	No.	%	No.	%	No.	%
Residence						
City of Boston	2,023		2,023	38%		
Remainder of Boston SMSA*			1,328	25%		
Remainder of Massachusetts			1,803	34%		
SubTotal	2,023		5,154	97%		
Out of State Residence			316	6%		
Transmission Mode (Adults)	1,989		5,355		238,095	
Homosexual/Bisexual Male	1,203	60%	2,927	55%	136,912	58%
I. V. Drug User	396	20%	1,308	24%	54,475	23%
Homosexual IV Drug Users	68	3%	220	4%	15,203	6%
Hemophiliac	9	0%	70	1%	1,953	1%
Heterosexual	223	11%	509	10%	15,221	6%
Blood Transfusion Recipient	20	1%	126	2%	4,833	2%
Undetermined	70	4%	195	4%	9,498	4%
Transmission Mode (Pediatric)	34		115		4,051	
Mother with AIDS/at risk for HIV	31	91%	100	87%	3,480	86%
Hemophiliac	1	3%	6	5%	183	5%
Blood Transfusion Recipient	2	6%	9	8%	303	7%
Undetermined	0	0%	0	0%	85	2%
Gender						
Male	1,782	88%	4,746	87%	214,315	89%
Female	241	12%	724	13%	27,831	11%
Mortality Status						
Alive	662	33%	1,878	34%	81,774	34%
Dead	1,361	67%	3,592	66%	160,372	66%
Race/Ethnicity						
White	1,182	58%	3,649	67%	127,317	53%
Black	659	33%	1,122	21%	71,984	30%
Hispanic	168	8%	660	12%	40,353	17%
Other/Unknown	14	1%	39	1%	2,492	1%
Age Group (years)						
Under 13	34	2%	115	2%	4,051	2%
13 - 19	1	0%	17	0%	912	0%
20 - 29	376	19%	1,073	20%	46,476	19%
30 - 39	1,051	52%	2,685	49%	110,849	46%
40 - 49	432	21%	1,167	21%	55,038	23%
Over 49	129	6%	413	8%	24,820	10%

*Total Cases reported as of October 1, 1992

** Refers to the Boston Standard Metropolitan Statistical Area

UPDATE:

In November, 86 AIDS Cases were reported to the AIDS Surveillance Program

CALENDAR

Asymptomatic HIV+ Support Group. To be held at the Fenway Community Health Center on the first three Wednesdays of every month from 7-9 p.m. (617) 267-0900 X287

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HIV Dental Ombudsperson Program Individuals with HIV/AIDS having trouble accessing or affording dental care can call (617) 534-4717 for help.

Case Manager, R.N. The VNA of Greater Lynn has a position open for a Case Manager reponsible for coordination of care of HIV-positive clients. Resumes should be sent to the VNA of Greater Lynn, 16 City Hall Square, Lynn, MA 01901.

AIDS NEWSLETTER
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AIDS NEWSLETTER

Vol. 9 No. 1 Monthly Publication of the Massachusetts Department of Public Health January, 1993

The Pediatric Spectrum of HIV Disease in Massachusetts

As of January 1, 1993, 115 cases of AIDS in children under the age of 13 have been reported to the Massachusetts AIDS Surveillance Program. Pediatric AIDS cases account for 2% of AIDS cases reported in Massachusetts, a percentage comparable to figures nationally.

The current surveillance definition for pediatric AIDS does not accurately reflect the extent of pediatric HIV-related morbidity and mortality. In order to estimate the total number of HIV-infected children in Massachusetts and to systematically review the clinical manifestations of pediatric HIV disease, the Massachusetts Department of Public Health initiated the "Pediatric Spectrum of Disease" (PSD) project in 1989.

Funded by the Centers for Disease Control (CDC), the PSD project is currently in its fourth year of data collection from study sites across the state. Data are received and recorded without personal identifiers. An annual provider survey conducted by PSD staff shows that the six participating hospitals provide care and get referrals for 96% of all pediatric HIV-infected children identified in Massachusetts. In addition to these hospital sites, a research nurse with the Department of Social Services (DSS) participates in the PSD project, providing additional clinical and demographic data on children who are in the custody of DSS. These hospital sites are responsible for updating the data on these children every six months. A total of 584 children of HIV-infected mothers have been enrolled in the PSD study as of December 1, 1992. Sixty of these children have died.

Children born to HIV infected mothers are classified in one of four P classification groups. P0's are perinatally exposed children younger than 15 months of age who have antibody to HIV with indeterminate infection. Children who are HIV infected but asymptomatic are classified as P1. P2's are children who have symptomatic HIV-infection. Some of these children have been diagnosed with AIDS; others although sick do not have a definitive/presumptive illness to classify them as having AIDS. P3's are those children who have seroreverted and are HIV negative. It is estimated that 70% to 75% of children born to HIV-infected mothers will become P3's. Table 1 shows the clinical status of the children followed by the PSD project.

Table 1

PEDIATRIC HIV CLASSIFICATION

- **P0 (indeterminate) n=106**
- **P1 (asymptomatic) n=23**
- **P2 (symptomatic) n=242**

(AIDS diagnosed = 108 Non-AIDS = 134)

- **P3 (seroreverter) n=213**

Because of the existence of the mother's antibody in the child, it is difficult to determine a child's infection status early in life. The ELISA and

Inside:

•Monthly Update....page 3
•Calendar..........page 4

Next Month:
T-Cell Testing in Massachusetts

For case reporting of AIDS patients meeting the CDC definition, please notify AIDS Epidemiologists at (617)522-3700, ext. 482 or 478.

Western Blot are the standard tests most commonly used for antibody testing. However some children born to HIV-infected mothers are tested using HIV culture, polymerase chain reaction (PCR) and P24 antigen assay. These tests may allow for earlier diagnosis of infection of these children but they remain investigational and of uncertain usefulness.

A common determinant of illness for both adults and children is the T helper lymphocyte (CD4+ cell) counts. These usually decline as HIV disease progresses. The normal range of the CD4+ cell count is quite different in young children than in adults both with and without HIV infection. For example, among HIV infected adults, a CD4+ cell count <200/mm3 is highly predictive of increased risk of Pneumocystis carinii pneumonia (PCP). Studies have shown that total lymphocytes and absolute CD4+ cell counts are much higher in healthy infants and young children than among healthy adults. Therefore, HIV-infected children can have marked depletion of CD4+ cells but have values that would fall within the normal range for CD4+ cell counts for adults. A typical CD4 cell count for a healthy non-HIV infected child who is one to six months old is 3200/mm3, with a progressive decline to 2600/mm3 between ages 13 - 24 months and to 1,700/mm3 by 2 to 6 years of age.(1)

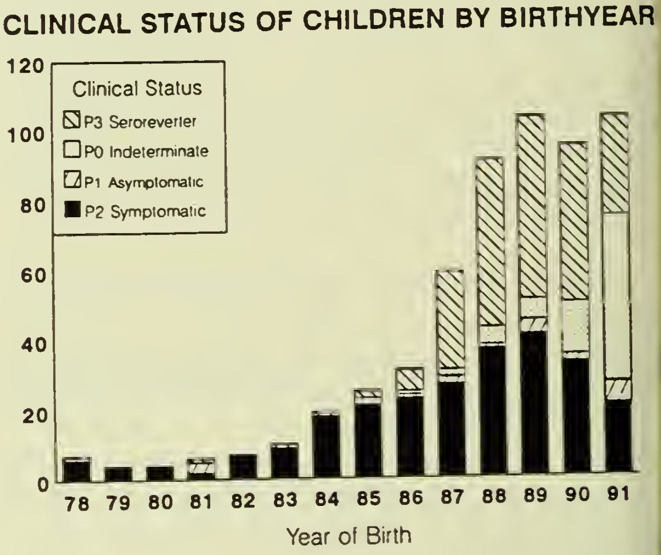
As in adults, PCP is the most common serious HIV-associated opportunistic infection among children in the PSD study. Other commonly reported AIDS defining illnesses for children in the PSD study are lymphoid interstitial pneumonia (LIP), recurrent bacterial infections, and HIV encephalopathy.

In addition, the interval from HIV-infection to the onset of symptoms of immunodeficiency is shorter in children than in adults. In the PSD project, of those children infected, 31% developed symptoms within the first six months of life while another 19% became symptomatic by the time they reached one year of age. Figure 1 summarizes the clinical status of children enrolled in the PSD project by year of birth.

PSD study data suggests that HIV infection in pregnant women is being increasingly recognized. Earlier in the study period, HIV infection in the mother was often recognized after the development of symptoms in the baby. Because of improved prenatal evaluation and screening, more HIV-infected women are identified during pregnancy and are offered services for themselves and their child. As one might expect, initial evaluations for children born to HIV-infected mothers are being performed earlier.

The predominant risk factor for the mothers of infants followed by the PSD project continues to be injecting drug use or having a sex partner who is an injecting drug user.

Figure 1



Remembering that all children enrolled in the PSD project have HIV-infected mothers, forty-four children have mothers known to have died. Approximately 63% are currently living with a biological parent and another 12% are being cared for by other relatives or foster parents who are relatives. Eighteen percent of the PSD enrolled children live with unrelated foster parents.

The PSD project will continue to follow these children and their families. Since the start of the project there has been a steady increase in the use of antiretroviral agents and PCP prophylaxis for children. As more treatments become available and are used, more children with HIV infection should survive well into their school years.

(1)MMWR 3/15/91 Vol. 40 No.RR-2

Guidelines for Prophylaxis Against PCP for Children Infected with HIV.

Note: Unlike the adult AIDS case definition in which four new conditions were added beginning January 1993, revision of the pediatric AIDS case definition is still under consideration by CDC.

AIDS SURVEILLANCE SUMMARY

	Boston		Massachusetts		United States*	
otal Cases reported as of 1/1/93	2,058		5,541		242,146	
	No.	%	No.	%	No.	%
esidence						
City of Boston	2,058		2,058	37%		
Remainder of Boston SMSA**			1,343	24%		
Remainder of Massachusetts			1,824	33%		
SubTotal	2,058		5,225	94%		
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I. V. Drug User	399	20%	1,326	24%	54,475	23%
Homosexual IV Drug Users	68	3%	224	4%	15,203	6%
Hemophiliac	10	0%	71	1%	1,953	1%
Heterosexual	229	11%	517	10%	15,221	6%
Blood Transfusion Recipient	21	1%	126	2%	4,833	2%
Undetermined	73	4%	198	4%	9,498	4%
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40 - 49	440	21%	1,191	21%	55,038	23%
Over 49	134	7%	417	8%	24,820	10%

otal Cases reported as of Oct 1, 1992

Refers to the Boston Standard Metropolitan Statistical Area

PDATE:

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HIV Dental Ombudsperson Program Individuals with HIV/AIDS having trouble accessing or affording dental care can call (617) 534-4717 for help.

Victory Dinner A free monthly dinner for people with AIDS/HIV disease, partners, families, friends, and people who have lost someone to AIDS. First Wednesday of every month at Our Lady of Victories Parish Hall, 27 Isabella St., Bay Village, Boston. Reservations necessary, please call (617) 482-5440.

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1993

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AIDS NEWSLETTER

Vol. 9 No. 2 Monthly Publication of the Massachusetts Department of Public Health February, 1993

A Survey of CD4+ Cell Testing in Massachusetts

Effective January 1, 1993, the Centers for Disease Control and Prevention (CDC) recommended that all states begin using an expanded AIDS surveillance definition for adolescents and adults. This new definition includes three additional clinical diagnoses - pulmonary tuberculosis, recurrent pneumonia, and invasive cervical carcinoma - while retaining the 23 clinical conditions used in the 1987 definition. To emphasize the role of severe immunosuppression in HIV-related clinical conditions, the CDC has also expanded the new AIDS surveillance definition to include all HIV-infected persons with CD4+ T-lymphocyte counts of <200 /uL or a CD4+ T-cell percentage of total lymphocytes of < 14%.

CD4+ cell counts are routinely used to assess the severity of a patient's immunodeficiency and to assist in the medical management of HIV-infected persons, specifically in regard to the use of retroviral therapy and prophylaxis. The inclusion of immunologic criteria in the AIDS case definition means that access to reliable CD4+ cell testing becomes a determinant of an AIDS diagnosis as well as an important aspect of clinical management. To determine the availability of CD4+ cell testing and the number of persons who might meet the new AIDS case definition in Massachusetts, a survey was conducted of all clinical laboratories in the state.

The survey was designed to gather information on both HIV antibody and CD4+ cell testing. The total number of HIV antibody tests performed and percent seropositive was requested. Laboratories performing CD4+ cell testing were asked to report total volume of testing and results by CD4 count and percentage of total lymphocytes. All data collected were estimates for calendar year 1991. Information on basic charges for testing was also requested.

A list of clinical laboratories in Massachusetts was provided by the federal Health Care Financing Administration and the Massachusetts Department of Public Health, Division of Health Care Quality. Laboratories were asked to provide the name of their reference laboratory if CD4+ cell testing was not performed on site. Those not performing CD4+ cell testing were asked if they planned to begin this testing during 1992. The survey was mailed during May of 1992 to 257 clinical laboratories in Massachusetts. Two hundred eight (81%) of the labs responded to the survey. Only fourteen laboratories reported performing CD4+ cell testing. Eight of the fourteen are located in Boston, three are within the Boston metropolitan area, and three are in other areas of the state. Four additional laboratories accept specimens for CD4+ cell counts but send them out of state for testing to two laboratories in New Jersey and one each in Minnesota and California. (See Table 1).

Eleven laboratories provided information on 13,954 T-cell test results by range of total CD4+ cells. Six laboratories (10,538 tests) provided results

Inside:
- **Monthly Update...page 3**
- **Calendar.........page 4**

Next Month:
AIDS Mortality in MA

For case reporting of AIDS patients meeting the CDC definition, please notify AIDS Epidemiologists at (617)522-3700, ext. 482 or 478.

of CD4+ cell counts as a percentage of total lymphocytes (see Table 2).

Thirty-three percent of the specimens tested (n=4,542) in these laboratories had CD4+ cell counts of less than 200/uL. Twenty-nine percent of CD4+ cell counts/total lymphocyte ratios were less than 14% (n=3066). It should be noted that the survey did not request numbers of individuals tested, but total number of tests. An unknown proportion of tests may have been repeat tests in the same patients. Individuals represented by these results who are also HIV+ now meet the new AIDS surveillance case definition.

TABLE I.
MA Laboratories Providing HIV/CD4+ Testing

	HIV	CD4+	Both
Testing:			
In state	27	14	12
Out-of-state	1	4	1
TOTAL	28	18	13

Eighty-five laboratories reported referral of CD4+ cell testing to other laboratories. Seventeen laboratories were cited as referral laboratories. Eight of the seventeen indicated that they were performing CD4+ cell testing. The other nine were referring the tests to out-of-state laboratories (6) or other in-state laboratories (3).

Six laboratories reported plans to begin CD4+ cell testing within the next year. Fifteen of the 18 laboratories accepting specimens indicated cost information for absolute CD4+, CD8+, CD4+/CD8+ ratios and % of CD4+ to total lymphocytes. Thirteen reported the cost of testing to be > $100 and two indicated the cost to be in the $50-$100 range.

While the purpose of this article is to report on CD4+ cell testing in Massachusetts, 27 laboratories in-state receive specimens for HIV antibody testing. Data from thirteen indicated 73,264 specimens were tested during 1991 with an average seroprevalence rate of 1.7%, (range from 0.5% to 8.3%). It was not possible to determine how many HIV tests were referred to laboratories out-of-state.

The implementation of the expanded AIDS surveillance case definition is expected to have significant impact on the number of AIDS cases reported to the Massachusetts Department of Public Health. Elsewhere in this newsletter it has been reported that 218 newly diagnosed AIDS cases have been reported during the first month of surveillance using the new definition. This represents a 125% increase in AIDS case reports over December, 1992; 126 (58%) of these new cases met only the new surveillance definition. Virtually all of the increase is due to the inclusion of CD4+ cell testing criteria in the AIDS case definition. Nationally, the CDC projects the increase in new AIDS cases in 1993 to be approximately 75% for a total of 85,000-90,000 new cases.

TABLE II.
CD4+ T-Cell Testing Results

T-Cell Counts		CD4+/Total Lymphpcytes	
T-Cell Range	No. Tests(%)*	CD4+ %	No. Tests(%)
>500	3737 (26)	>20%	5316 (50)
200-499	5675 (41)	14-20%	2156 (21)
≤200	4542 (33)	<14%	3066 (29)
TOTAL	13,954		10,538

*This number refers to the number of individual tests and may include repeat tests on the same individuals.

The increased use of CD4+ cell enumeration brings increase attention to issues of accuracy and reliability. The National Laboratory Training Network (NLTN) is planning to conduct a number of workshops on "Flow Cytometric Immunophenotyping Quality Assurance and Quality Control Procedures for CD4+ T-lymphocyte Determinations". One of these three day workshops will be held in New England (date and site to be determined). For further information contact the New England Area Resource Office of the NLTN at (617) 522-3700, ext. 135.

Reminder To Our Readers: You must notify the AIDS Surveillance Office by March 20, 1992 or your name will be deleted from our mailing list.

AIDS SURVEILLANCE SUMMARY

	Boston		Massachusetts		United States*	
Total Cases reported as of 2/1/93	2114		5744		242,146	
	No.	%	No.	%	No.	%
Residence						
City of Boston	2,114		2,114	40%		
Remainder of Boston SMSA*			1,417	27%		
Remainder of Massachusetts			1,890	36%		
SubTotal	2,114		5,421	102%		
Out of State Residence			323	6%		
Transmission Mode (Adults)	2,077		5,624		238,095	
Homosexual/Bisexual Male	1,243	60%	3,028	54%	136,912	58%
I. V. Drug User	427	21%	1,427	25%	54,475	23%
Homosexual IV Drug Users	71	3%	233	4%	15,203	6%
Hemophiliac	10	0%	74	1%	1,953	1%
Heterosexual	230	11%	531	9%	15,221	6%
Blood Transfusion Recipient	21	1%	128	2%	4,833	2%
Undetermined	75	4%	203	4%	9,498	4%
Transmission Mode (Pediatric)	37		120		4,051	
Mother with AIDS/at risk for HIV	34	92%	104	87%	3,480	86%
Hemophiliac	1	3%	7	6%	183	5%
Blood Transfusion Recipient	2	5%	9	8%	303	7%
Undetermined	0	0%	0	0%	85	2%
Gender						
Male	1,857	88%	4,974	87%	214,315	89%
Female	257	12%	770	13%	27,831	11%
Mortality Status						
Alive	726	34%	2,062	36%	81,774	34%
Dead	1,388	66%	3,682	64%	160,372	66%
Race/Ethnicity						
White	1,235	58%	3,824	67%	127,317	53%
Black	689	33%	1,171	20%	71,984	30%
Hispanic	176	8%	709	12%	40,353	17%
Other/Unknown	14	1%	40	1%	2,492	1%
Age Group (years)						
Under 13	37	2%	120	2%	4,051	2%
13 - 19	1	0%	17	0%	912	0%
20 - 29	388	18%	1,100	19%	46,476	19%
30 - 39	1,091	52%	2,816	49%	110,849	46%
40 - 49	457	22%	1,253	22%	55,038	23%
Over 49	140	7%	438	8%	24,820	10%

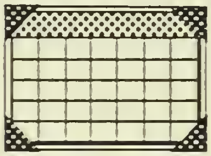
*Total Cases reported as of October 1, 1992

** Refers to the Boston Standard Metropolitan Statistical Area

UPDATE:

n January, 218 AIDS Cases were reported to the AIDS Surveillance Program, 58% met the new case definition.

CALENDAR



Asymptomatic HIV+ Support Group To be held at the Fenway Community Health Center on the first three Wednesdays of every month from 7-9 p.m. Call (617) 267-0900 X287.

"Positive Directions" will hold a support group for gay couples of mixed HIV status. Offered the 1st and 3rd Monday of each month at Positive Directions, for information call Will Escobar at (617) 262-3456. Positive Directions also sponsors a peer support line (617) 247-7337.

Support Group for Caregivers To be held on the second and fourth Wednesday of each month at the Brockton V.N.A. For information call Kim Jordan at (508) 587-2121.

HIV+ Support Services The Shattuck Adult Day Health Center offers support servivces for HIV-infected individuals. For more information, please call Andrea Roger at (617) 522-8110 X328 or 341.

Weekly Spiritual Support Group The Boston Catholic Archdiocese offers this free Tuesday support group at 7:30 p.m. for PWAs/HIV+ individuals and their caregivers. Call (617) 482-5440.

HIV Dental Ombudsperson Program Individuals with HIV/AIDS having trouble accessing or affording dental care can call (617) 534-4717 for help.

Victory Dinner A free monthly dinner for people with AIDS/HIV disease, partners, families, friends, and people who have lost someone to AIDS. First Wednesday of every month at Our Lady of Victories Parish Hall, 27 Isabella St., Bay Village, Boston. Reservations necessary, please call (617) 482-5440.

"The New Definition of AIDS: What Does It Mean For Our Clients?", a free program sponsored by the Boston AIDS Consortium in conjunction with the DPH AIDS Bureau. The program will take place on Thursday, March 4, 1993 from 3:00 to 5:00 p.m. (preceeded at 2:30 by CEU registration) at the Harvard School of Public Health, room G1. Call Christie Burke at 727-0368 for additional information.

AIDS NEWSLETTER
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February
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AIDS NEWSLETTER

Vol. 9 No. 3 Monthly Publication of the Massachusetts Department of Public Health March, 1993

Years of Life Lost: The Human Toll of AIDS

There has been a steady decrease in the age-adjusted death rate in Massachusetts over the past decade. Massachusetts' age-adjusted death rate is nearly 10% lower than that of the U.S. and has been consistently lower throughout the 80's. During 1991, over 53,000 Massachusetts residents died. More than half of these deaths occurred in people over 75 years of age. In 1991, heart disease, stroke and all cancers combined were responsible for nearly 65% of the total deaths and AIDS accounted for 1.3%, but deaths due to AIDS increased each year during the 80's and will continue to increase for the next several years.

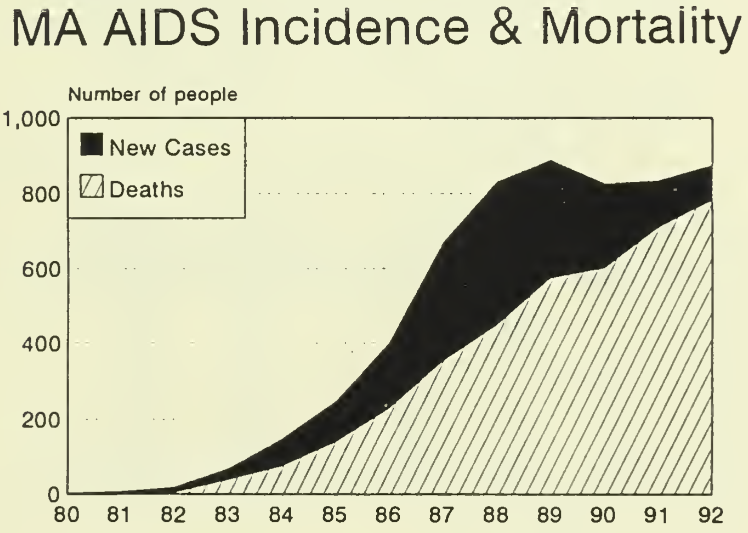
The Bureau of Health Statistics, Research and Evaluation of the Massachusetts Department to Public Health estimates the impact of specific diseases by calculating total years of life lost (TYLL)[1]. This measure is calculated by multiplying all deaths due to specific causes within 10 year age groups by years of life lost in that specific age group. These numbers are added to determine TYLL. Years lost due to many preventable causes of deaths have declined over the past five years. There has been a 15% decline in TYLL due to both injuries/accidents and heart disease. This decrease is partly due to preventive measures and better medical interventions. There are two major exceptions to the downward trend: cancer which was associated with a 7% increase in TYLL and AIDS which was associated with a 168% increase in TYLL over the past five years. More than 207,000 TYLL were due to cancer in 1991, the disease with the largest number of years lost. AIDS and HIV-related disease accounted for more than 26,000 TYLL.

Inside:
- ♦ *Monthly update........page 3*
- ♦ *Calendar................page 4*

Next Month:
- ♦ *Reporting Delay in Mass.*

The impact of AIDS can be seen more vividly by looking at the impact on average years of life lost. This measure is a reflection of premature death compared to an individual's statistical life expectancy. Cancer deaths account for average individual YLL of 15 years, whereas HIV/AIDS accounts for 42 years lost. The average age of death for a person with cancer is 63 years compared to 38 for a person with AIDS.

Figure 1



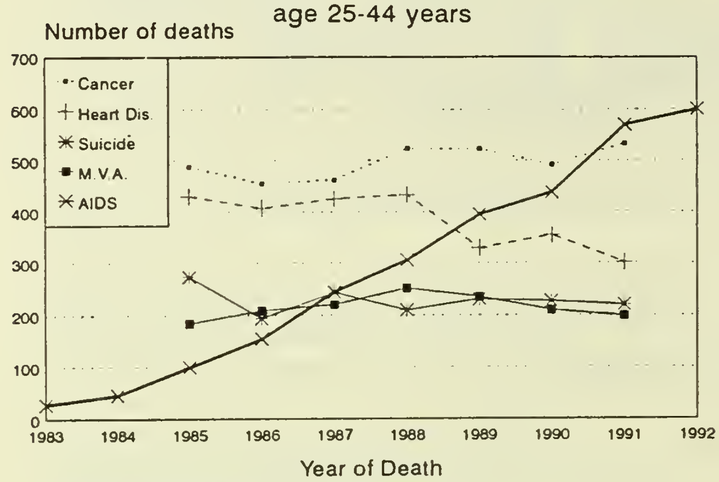
1992 values are estimations

♦ Figure 1 presents AIDS incident cases (newly diagnosed each year) and the number of deaths among AIDS cases each year. The leveling of incident cases seen since mid-1989 is evident and contrasts with the increasing number of deaths per year. The number of deaths per year is continuing to increase and is expected to increase 10-15 % each year for the next several years.

For case reporting of AIDS patients meeting the CDC definition, please notify AIDS Epidemiologists at (617)522-3700, ext. 482 or 478.

Figure 2

Causes of Death in Massachusetts
age 25-44 years



* 1992 Estimated values based on preliminary data

◆ Figure 2 shows changes in the past several years for death due to specific causes among 25 - 44 year old Massachusetts residents. Number of deaths due to motor vehicular accidents (MVA) and suicide have remained fairly constant, the numbers of deaths due to heart disease have declined and deaths due to cancer increased slightly over the past several years. The most dramatic change in this age range has been the increase in deaths due to AIDS from 100 in 1985 to an estimated 600 seven years later. In Massachusetts, this averages two deaths per day within this age group.

Table 1

Year	Race			Place of Death			Total
	White	Black	Hispanic	Hospital	Home	Hospice	
1985	70%	22%	8%	88%	6%	1%	128
1986	71%	19%	11%	82%	12%	1%	200
1987	70%	19%	10%	82%	12%	1%	324
1988	70%	20%	9%	75%	17%	1%	407
1989	68%	21%	10%	74%	18%	1%	521
1990	68%	21%	11%	62%	18%	15%	584
1991	68%	18%	13%	56%	20%	21%	723
1992*	66%	22%	12%	54%	21%	22%	808

% of Total AIDS deaths per year

** Estimated values based on preliminary data*

◆ The racial distribution of deaths due to AIDS parallels the disparities seen in incident AIDS cases. The enormous impact of AIDS on communities of color in Massachusetts is dramatically demonstrated when analyzing vital statistics. Of the 1,800 Blacks of all ages who died in 1991, 7% were diagnosed with AIDS; of the estimated 680 Hispanics who died, 13% were diagnosed with AIDS. Only 1% of Whites who died in 1991 died of AIDS. In both Blacks and Hispanics, HIV/AIDS was the second leading cause of death overall and the number one cause of death for males.

◆ One of the marked trends in AIDS deaths is the movement away from hospital settings toward home and hospice residential settings. As table 1 shows, only 7% of 1985 AIDS deaths in Massachusetts occurred outside a hospital setting. Estimates for 1992 deaths are that 43% of people dying of AIDS die in a non-hospital setting. Before 1990, the only non-hospital place of death was at home. In 1990, the Hospice at Mission Hill in Boston opened as an 18-bed residential hospice program specializing in HIV/AIDS care, one of the first in the country. This single facility accounted for an estimated 20% of all 1992 AIDS deaths in Massachusetts.

AIDS is one of the most devastating of all the preventable causes of death in Massachusetts. The young age of death, the years of productive life lost, the protracted and painful dying process and the immeasurable affect on family, lovers, parents, friends and care givers tell part of the story. In addition, the economic burden of providing care to an HIV-infected individual during the last year of life is enormous. The cost of care ranges from $50,000 to $100,000 per person.

Despite behavior modification and prevention activities targeted to those most at risk, an estimated 27,000-41,000 Massachusetts individuals are currently infected with HIV. The 3,500 AIDS related deaths since the early 1980's have already strained our social and health care systems. In the next decade we will have to deal with thousands of inevitable HIV-related deaths.

---

1. Advanced Data Deaths (1987 - 1991), Massachusetts Department of Public Health, Bureau of Health Statistics, Research & Evaluation.

HIV DRUG REIMBURSEMENT FOR:

✓AZT (Retrovir) ✓αInterferon ✓Dapsone ✓Foscarnet (Foscavir) ✓Nystatin (Mycostatin) ✓Sulfadiazine ✓Butaconazole (Femstat) ✓ddI (Videx) ✓Aerosolized Pentamidine ✓Trimethoprim/sulfa (Bactrim) ✓Fluconazole ✓Clotrimazole (Mycelex) ✓Clindamycin ✓Terconazole ✓ddC (HIVID) ✓Acyclovir ✓Ganciclovir ✓Ketoconazole ✓Pyrimethamine ✓Leucovorin

For more information on the HDRP see announcements on the last page of this newsletter.

AIDS SURVEILLANCE SUMMARY

	Boston		Massachusetts		United States*	
	2,160		5,941		253,448	
otal Cases reported as of 3/1/93	No.	%	No.	%	No.	%
esidence						
City of Boston	2,160		2,160	36%		
Remainder of Boston SMSA**			1,475	25%		
Remainder of Massachusetts			1,974	33%		
SubTotal	2,160		5,609	94%		
Out of State Residence			332	6%		
ransmission Mode (Adults)	2,123		5,821		249,199	
Homosexual/Bisexual Male	1,269	60%	3,083	53%	142,626	57%
I. V. Drug User	441	21%	1,500	26%	57,412	23%
Homosexual IV Drug Users	73	3%	237	4%	15,899	6%
Hemophiliac	11	1%	113	2%	2,026	1%
Heterosexual	232	11%	547	9%	16,254	7%
Blood Transfusion Recipient	22	1%	131	2%	4,980	2%
Undetermined	75	4%	210	4%	10,002	4%
ransmission Mode (Pediatric)	37		120		4,249	
Mother with AIDS/at risk for HIV	34	92%	104	87%	3,665	86%
Hemophiliac	***		7	6%	188	4%
Blood Transfusion Recipient	***		9	8%	306	7%
Undetermined	***		***		90	2%
ender						
Male	1,897	88%	5,138	86%	223,971	88%
Female	263	12%	803	14%	29,477	12%
ortality Status						
Alive	750	35%	2,191	37%	81,558	32%
Dead	1,410	65%	3,750	63%	171,890	68%
ace/Ethnicity						
White	1,257	58%	3,941	66%	132,625	52%
Black	701	32%	1,208	20%	75,997	30%
Hispanic	184	9%	745	13%	42,199	17%
Other/Unknown	18	1%	47	1%	2,627	1%
ge Group (years)						
Under 13	37	2%	120	2%	4,249	2%
13 - 19	***		24	0%	946	0%
20 - 29	399	18%	1,146	19%	48,295	19%
30 - 39	1,118	52%	2,908	49%	115,918	46%
40 - 49	462	21%	1,288	22%	57,987	23%
Over 49	143	7%	455	8%	26,053	10%

otal Cases reported as of Jan 1, 1993

Refers to the Boston Standard Metropolitan Statistical Area

*Less than 5 reported

PDATE:

February, 201 AIDS Cases were reported to the AIDS Surveillance Program, 65% met the new AIDS case finition criterion and twenty percent were diagnosed before 1992.

CALENDAR & ANNOUNCEMENTS

The HIV Drug reimbursement program announces an important change in their drug distribution system. Please request and fill out a new application for the HIV Drug Reimbursement Plan Mail Service Prescription Drug Program which will replace the present retail pharmacy system. For an application please call Joseph Montañez at (617)262-0889.

Asymptomatic HIV+ Support Group To be held at the Fenway Community Health Center on the first three Wednesdays of every month from 7-9 p.m. Call (617) 267-0900 x287.

Support Group for Caregivers To be held on the second and fourth Wednesday of each month at the Brockton V.N.A. For information call Kim Jordan at (508) 587-2121.

HIV+ Support Services The Shattuck Adult Day Health Center offers support servivces for HIV-infected individuals. For more information, please call Andrea Roger at (617) 522-8110 x328 or x341.

Weekly Spiritual Support Group The Boston Catholic Archdiocese offers this free Tuesday support group at 7:30 p.m. for PWAs/HIV+ individuals and their caregivers. Call (617) 482-5440.

HIV Dental Ombudsperson Program Individuals with HIV/AIDS having trouble accessing or affording dental care call (617) 534-4717 for help.

Victory Dinner A free monthly dinner for people with AIDS/HIV disease, partners, families, friends, and people who have lost someone to AIDS. First Wednesday of every month at Our Lady of Victories Parish Hall, 27 Isabella St., Bay Village, Boston. Reservations necessary, please call (617) 482-5440.

Support groups offered by the Consortium for Better Living with HIV Disease in the Greater Haverill/southern NH area. For more information, please call Bill Comeau at (508) 374-2437.

Neponset Health Center in Dorcester has an ongoing **support and discussion group** for friends, family and significant others of people with HIV/AIDS. Every 2nd and 4th Tuesday. Call Jo (282-3200) or Jeff (232-9500 x4669) for info.

AIDS NEWSLETTER
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AIDS NEWSLETTER

Vol. 9 No. 4 Monthly Publication of the Massachusetts Department of Public Health April, 1993

Timeliness of AIDS Case Reporting

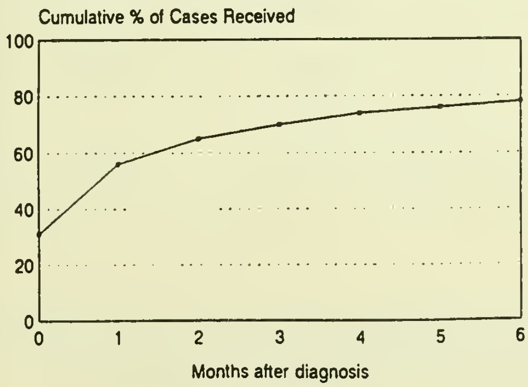
In 1983, the federal Centers for Disease Control formulated an AIDS case definition to monitor the AIDS epidemic in the United States. Complete and timely AIDS case reporting by health care providers is necessary to detect trends in the AIDS epidemic. These statistics also guide resource allocation. Title I and II funds under the Ryan White Act are distributed to cities and states through a formula based on reported AIDS cases.

This article will describe an analysis of the time (in months) between AIDS diagnosis and the report of a case (called "reporting delay") to the Massachusetts Department of Public Health. Analysis is through the end of 1992. Reporting delay for persons meeting the new AIDS case definition, implemented January 1, 1993, is likely to be significantly longer due to retrospective reporting. Therefore, AIDS cases reported since January 1, 1993 have been excluded from this analysis.

Fifty-six percent of all AIDS cases were reported within one month of diagnosis. An additional twenty-two percent were reported within two to six months. The remaining 22% of cases were reported more than six months after diagnosis. Reporting lag varies slightly between modes of transmission. Cases attributable to male to male sex or heterosexual sex with someone at risk were somewhat more likely to be reported earlier than those related to injection drug use (IDU). There were no significant differences in reporting delay related to race or gender (see Table 1).

Figure 1

Reporting Delay from Massachusetts Facilities:
All Cases



Source: MA AIDS Surveillance Program
1/93

Timeliness of reporting varies by diagnosing facility. Special attention continues to be given to all hospitals, and especially to outpatient facilities, who may have difficulties reporting AIDS cases on a timely basis. In general, cases diagnosed as outpatients are reported later than inpatient cases. Cases found by alternative surveillance methods (i.e. death certificate review), as expected, are also reported later than those ascertained through our routine surveillance methods. However, these account for small numbers of cases and even when these cases are eliminated, reporting delay does not improve. Reporting delay has increased over time. Ninety-one percent of 1986 cases were reported within six months of diagnosis, 67% in 1991 and 73% in 1992 (see Table 1).

Timely reporting of AIDS cases is critical in effectively monitoring the epidemiology of AIDS in Massachusetts as well as for making predictions about future directions. In addition many decisions about

Inside:
- ◆ Increased Reporting...page 2
- ◆ Monthly Update....page 3
- ◆ Calendar..........page 4

Next Month:
- ◆ Investigating Risk

For case reporting of AIDS patients meeting the CDC definition, please notify AIDS Epidemiologists at (617)522-3700, ext. 482 or 478.

AIDS SURVEILLANCE SUMMARY

	Boston		Massachusetts		United States*	
Total Cases reported as of 4/1/93	2,311		6,273		253,448	
	No.	%	No.	%	No.	%
Residence						
City of Boston	2,311		2,311	37%		
Remainder of Boston SMSA**			1,528	24%		
Remainder of Massachusetts			2,095	33%		
SubTotal	2,311		5,934	95%		
Out of State Residence			339	5%		
Transmission Mode (Adults)	**2,274**		**6,152**		**249,199**	
Homosexual/Bisexual Male	1,323	58%	3,210	52%	142,626	57%
I. V. Drug User	505	22%	1,639	27%	57,412	23%
Homosexual IV Drug Users	77	3%	246	4%	15,899	6%
Hemophiliac	12	1%	115	2%	2,026	1%
Heterosexual	255	11%	587	10%	16,254	7%
Blood Transfusion Recipient	25	1%	134	2%	4,980	2%
Undetermined	77	3%	221	4%	10,002	4%
Transmission Mode (Pediatric)	**37**		**121**		**4,249**	
Mother with AIDS/at risk for HIV	34	92%	105	87%	3,665	86%
Hemophiliac	***		7	6%	188	4%
Blood Transfusion Recipient	***		9	7%	306	7%
Undetermined	***		***		90	2%
Gender						
Male	2,023	88%	5,411	86%	223,971	88%
Female	288	12%	862	14%	29,477	12%
Mortality Status						
Alive	860	37%	2,442	39%	81,558	32%
Dead	1,451	63%	3,831	61%	171,890	68%
Race/Ethnicity						
White	1,315	57%	4,122	66%	132,625	52%
Black	775	34%	1,316	21%	75,997	30%
Hispanic	201	9%	786	13%	42,199	17%
Other/Unknown	20	1%	49	1%	2,627	1%
Age Group (years)						
Under 13	37	2%	121	2%	4,249	2%
13 - 19	***		25	0%	946	0%
20 - 29	425	18%	1,206	19%	48,295	19%
30 - 39	1,195	52%	3,071	49%	115,918	46%
40 - 49	497	22%	1,372	22%	57,987	23%
Over 49	156	7%	478	8%	26,053	10%

*Total Cases reported as of Jan 1, 1993

** Refers to the Boston Standard Metropolitan Statistical Area

***Less than 5 reported

UPDATE:

In March, 332 AIDS Cases were reported to the AIDS Surveillance Program, 50% met the new AIDS case definition

HIV resource allocation, at both a local and national level, are dependent on the use of AIDS surveillance data. Health care providers must continue to report all information about AIDS cases in a complete and timely manner so that these objectives can be met.

TABLE 1

CUMULATIVE PERCENT OF AIDS CASES REPORTED FROM MASS. FACILITIES WITHIN SIX MONTHS OF DIAGNOSIS
1/1/86 - 12/31/92

	Months After Diagnosis			
	<1	1	2	6
ALL CASES	31%	56%	65%	78%
Male/Male Sex	31%	56%	65%	78%
Heterosexual	33%	60%	70%	82%
IDU	31%	54%	63%	78%
Male	31%	56%	64%	78%
Female	32%	55%	66%	79%
White	31%	56%	65%	78%
Black	31%	53%	63%	78%
Latino	29%	56%	65%	78%
Year of Report -- All Cases				
1986	33%	65%	77%	91%
1987	36%	66%	75%	91%
1988	30%	58%	68%	81%
1989	38%	63%	72%	87%
1990	30%	54%	62%	72%
1991	26%	45%	54%	67%
1992	27%	50%	58%	73%
Active Surveillance	<1%	5%	10%	26%
Passive Surveillance	36%	63%	73%	86%
Inpatient Dx	33%	58%	66%	79%
Outpatient Dx	24%	45%	57%	73%

NOTE: Analysis excludes cases reported before 1986. ARS was obtained in Jan. 1986, and entry dates for cases reported prior to this date are unreliable.
Source: MA AIDS Surveillance Program, 1/93

Massachusetts AIDS Cases Increase

During the first three months of 1993, 751 cases of AIDS meeting the new and old case definitions were reported in Massachusetts. This represents a 192 percent increase over the 257 AIDS cases reported during the same three months of 1992. With the addition of these new cases, a total of 6,273 AIDS cases have been reported in the state since the beginning of the epidemic.

The increase in reporting has resulted in nearly four times the number of expected AIDS cases in current or former injecting drug users and a 242 percent increase in AIDS cases from communities of color when compared to the same three months of 1992.

The Department of Public Health AIDS Surveillance Program believes that the increase is due to recent efforts to encourage health care providers to report AIDS cases as well as the implementation of the expanded AIDS case definition. On January 1, the Centers for Disease Control and Prevention expanded the definition of AIDS to include persons with a CD4 lymphocyte count of less than 200 per mm3, an indicator of severe immunosuppression. HIV positive persons with cervical cancer, pulmonary tuberculosis, and recurrent pneumonia are also included in the AIDS case definition.

The 192% increase is more than twice the 75% increase originally anticipated nationwide by the CDC and more than three times that noted in New York City. Massachusetts health officials expect this rate in reporting of AIDS cases to continue for at least the next several months.

Figure 1 Comparison of Transmission Modes
among AIDS Cases Reported Pre-1993 and 1993

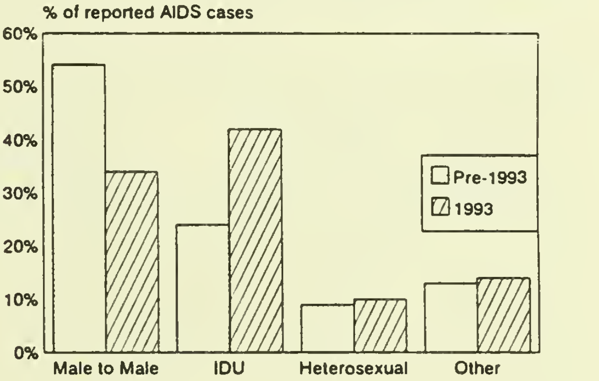
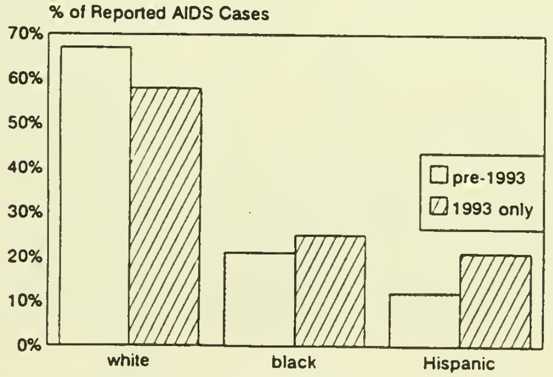


Figure 2. Comparison of Race/Ethnicity
among AIDS Cases Reported Pre-1993 and 1993



For case reporting of AIDS patients meeting the CDC definition, please notify AIDS Epidemiologists at (617)522-3700, ext. 482 or 478.

CALENDAR

Asymptomatic HIV+ Support Group To be held at the Fenway Community Health Center on the first three Wednesdays of every month from 7-9 p.m. Call (617) 267-0900 X287.

"Positive Directions" will hold a support group for gay couples of mixed HIV status. Offered the 1st and 3rd Monday of each month at Positive Directions, for information call Will Escobar at (617) 262-3456. Positive Directions also sponsors a peer support line (617) 247-7337.

Support Group for Caregivers To be held on the second and fourth Wednesday of each month at the Brockton V.N.A. For information call Kim Jordan at (508) 587-2121.

HIV+ Support Services The Shattuck Adult Day Health Center offers support servivces for HIV-infected individuals. For more information, please call Andrea Roger at (617) 522-8110 X328 or 341.

Weekly Spiritual Support Group The Boston Catholic Archdiocese offers this free Tuesday support group at 7:30 p.m. for PWAs/HIV+ individuals and their caregivers. Call (617) 482-5440.

HIV Dental Ombudsperson Program Individuals with HIV/AIDS having trouble accessing or affording dental care can call (617) 534-4717 for help.

Victory Dinner A free monthly dinner for people with AIDS/HIV disease, partners, families, friends, and people who have lost someone to AIDS. First Wednesday of every month at Our Lady of Victories Parish Hall, 27 Isabella St., Bay Village, Boston. Reservations necessary, please call (617) 482-5440.

HIV Conference to be held at the John Hancock Conference Hall on April 28, 1993. For more information, please call Dianna Christmas at (617) 442-8800 at the Dimmock Community Health Center.

Strongest Link provides several support groups for individuals with HIV/AIDS and their caregivers. In addition the organization provides case management, practical support, information and referrals. For more information please call (508) 887-0090.

AIDS NEWSLETTER
is a publication of the
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April
1993

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AIDS NEWSLETTER

Vol. 9 No. 5 Monthly Publication of the Massachusetts Department of Public Health May, 1993

INVESTIGATING AIDS CASES WITH NO IDENTIFIED RISK FOR HIV TRANSMISSION

Various modes of HIV transmission have been documented since the early 1980's. Sexual contact, percutaneous exposures through sharing of needles or occupational hazards, receipt of blood products, and perinatal exposure have all been shown to spread HIV infection.

Based on what is known about the epidemiology of AIDS, the Centers for Disease Control (CDC) has developed a system for the hierarchical classification of recognized risk into twenty-six categories. Persons reported with AIDS who do not report one of these risks are classified as having "no identified risk" (NIR) for HIV infection.

Cases with an undetermined risk represent four percent of the 250,000 adult and adolescent AIDS cases reported in the United States as of December 31, 1992. To date in Massachusetts, 444 AIDS cases (7%) have initially been reported as NIR cases. Most cases are originally classified this way as the result of incomplete or missing information. Follow-up with health care providers may allow us to quickly reclassify an AIDS patient into the most relevant risk group.

Although the number of NIRs in Massachusetts is relatively small, epidemiologic follow-up of these cases is given a high priority. Through NIR investigations we are able to: 1) reclassify persons initially identified as having an undetermined risk into an established transmission category , 2) describe persons with AIDS who remain in the NIR category, and 3) monitor trends in NIR cases over time.

Inside:
- Monthly Update...page 3
- Calendar...page 4

Next Month:
- IDU-Related Epidemiology

Investigation of NIR cases may help us to identify any new or unusual methods of HIV transmission. Information about transmission in the dental setting and through organ transplantation were initially uncovered by NIR investigation. In addition, the investigation of persons with an undetermined risk for HIV transmission may alleviate public concern about the potential for casual transmission of HIV.

Persons with AIDS may be classified as NIRs for several reasons. Some NIR cases may have a known transmission risk but may be unwilling to discuss sensitive information. In addition, some persons with AIDS may lack complete knowledge about the modes of transmission of HIV or may not be aware of the risk status of a sex partner. For example, a woman with AIDS may be unaware that her former sex partner was a bisexual or a male with AIDS may not have known that a former sex partner was an injecting drug user.

The AIDS Surveillance Program makes an attempt to follow-up on all NIR cases within six months from the date that they were originally reported. Priority is given to those NIRs who may have acquired their infection through occupational exposures (i.e. health care workers) or as a result of a transfusion received after March of 1985 (when routine screening of the blood supply was initiated). The first step in our investigation is to contact health care providers (including primary care physicians, case managers and nurses) who may be aware of the

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For case reporting of AIDS patients meeting the CDC definition, please notify AIDS Epidemiologists at (617)522-3700, ext. 482 or 478.

person's risk for HIV transmission. Medical records or ancillary records may also be reviewed in an attempt to determine risk status.

In some cases, this information is not immediately available. In this situation, an attempt is made to interview the AIDS patient. The interview, which takes about 45 minutes, attempts to elicit information about sexual behavior, drug use, medical history, occupational exposures, and invasive medical and dental procedures. All interviews are completely voluntary and confidential, and are scheduled with the cooperation of the patient's primary care provider.

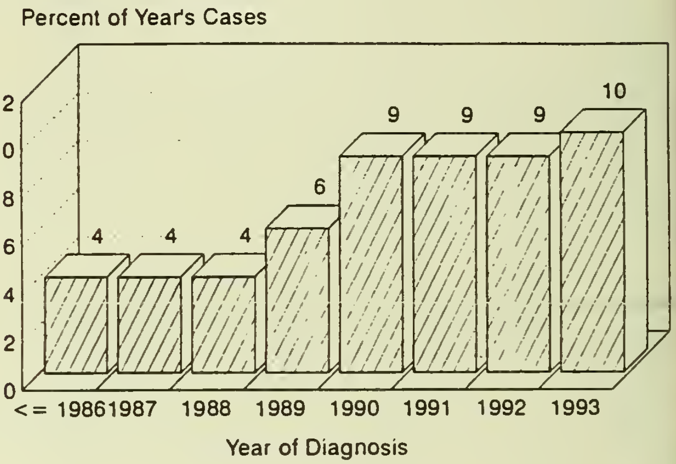
TABLE 1. STATUS OF MASSACHUSETTS NIR CASES

Reclassified		179
*Gay/bisexual	91	
*IDU	36	
*Gay/IDU	2	
*Heterosexual	41	
*Other	9	
Not reclassified		182
*Interviewed, no risk determined	26	
*Refused interview	35	
*Dead	47	
*Lost to follow-up	20	
*Possible Occup. Exposure	5	
*Prostitute Contact	33	
*Multiple Heterosexual Partners	16	
Still Under Investigation		83

Table 1 summarizes the status of 444 Massachusetts AIDS cases that were originally classified as NIRs. Forty percent of these cases (n= 179) have been reclassified into various exposure categories. Risk status was not identified in one hundred and twenty-eight cases (29%) (i.e. interviewed, no risk determined, refused interview, lost to follow-up, or dead). Thirty-three persons with prostitute contact were identified. Another 15 reported multiple sexual partners as a possible risk for HIV transmission. However, neither of these risk behaviors are included in the CDC's hierarchical classification system and therefore these patients cannot be reclassified. Eighty-three NIRs still remain open and are currently under investigation.

Figure 1 shows the trends in initially identified NIR cases in Massachusetts. NIRs have increased from 4% of cases diagnosed in 1988 and before to 10% of cases diagnosed year to date in 1993. Reasons for this increase are unclear but may be related to an increase in incompleteness of reporting forms, incomplete assessment of risk by health care providers, or the increasing number of heterosexually-acquired AIDS cases (many who may be initially identified as NIR).

FIGURE 1. TRENDS IN MA NIR CASES



Accurate information about the modes of transmission of HIV is essential for a variety reasons including:

- monitoring trends in transmission categories
- recognizing unusual situations for HIV transmission
- providing accurate statistical information on transmission patterns for projection purposes
- assisting in targeting prevention activities, funding, and other public health programs to populations at increased risk

Continued emphasis on NIR investigations, particularly in persons with suspected new or unusual transmission circumstances, will allow the MDPH to accomplish these goals.

AIDS SURVEILLANCE SUMMARY

	Boston		Massachusetts		United States*	
Total Cases reported as of 5/1/93	2,508		6,645		253,448	
	No.	%	No.	%	No.	%
Residence						
City of Boston	2,508		2,508	38%		
Remainder of Boston SMSA**			1,600	24%		
Remainder of Massachusetts			2,194	33%		
SubTotal	2,508		6,302	95%		
Out of State Residence			343	5%		
Transmission Mode (Adults)	2,471		6,518		249,199	
Homosexual/Bisexual Male	1,377	56%	3,305	51%	142,626	57%
I. V. Drug User	605	24%	1,808	28%	57,412	23%
Homosexual IV Drug Users	84	3%	256	4%	15,899	6%
Hemophiliac	13	1%	120	2%	2,026	1%
Heterosexual	271	11%	629	10%	16,254	7%
Blood Transfusion Recipient	27	1%	140	2%	4,980	2%
Undetermined	94	4%	260	4%	10,002	4%
Transmission Mode (Pediatric)	37		127		4,249	
Mother with AIDS/at risk for HIV	34	92%	111	87%	3,665	86%
Hemophiliac	***		7	6%	188	4%
Blood Transfusion Recipient	***		9	7%	306	7%
Undetermined	***		***		90	2%
Gender						
Male	2,177	87%	5,690	86%	223,971	88%
Female	331	13%	955	14%	29,477	12%
Mortality Status						
Alive	1,006	40%	2,684	40%	81,558	32%
Dead	1,502	60%	3,961	60%	171,890	68%
Race/Ethnicity						
White	1,383	55%	4,288	65%	132,625	52%
Black	864	34%	1,439	22%	75,997	30%
Hispanic	240	10%	866	13%	42,199	17%
Other/Unknown	21	1%	52	1%	2,627	1%
Age Group (years)						
Under 13	37	1%	127	2%	4,249	2%
13 - 19	***		27	0%	946	0%
20 - 29	461	18%	1,285	19%	48,295	19%
30 - 39	1,300	52%	3,256	49%	115,918	46%
40 - 49	548	22%	1,460	22%	57,987	23%
Over 49	161	6%	490	7%	26,053	10%

*Total Cases reported as of Jan 1, 1993

** Refers to the Boston Standard Metropolitan Statistical Area

***Less than 5 reported

UPDATE:

In April, 375 AIDS Cases were reported to the AIDS Surveillance Program, 69% met the new AIDS case definition

CALENDAR

From All Walks of Life The annual AIDS Pledge Walk will take place on June 6, beginning at 9 a.m. at Boston Common. Pledge sheets available by calling (617) 424-WALK.

Massachusetts AIDS Discrimination Initiative (MADI) provides information and advocacy for people needing assistance in dealing with HIV-related discrimination. Call (800) AIDS-808.

Asymptomatic HIV+ Support Group held at the Fenway Community Health Center first three Wednesdays of every month from 7-9 p.m. Call Gail at (617) 267-0900 X283.

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AIDS NEWSLETTER

Vol. 9 No. 6 Monthly Publication of the Massachusetts Department of Public Health June, 1993

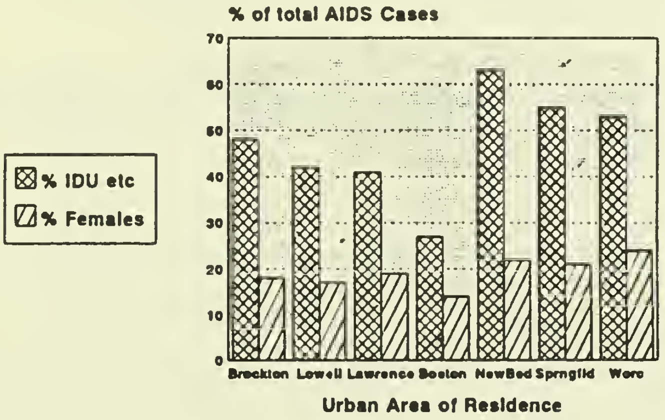
Update: Injecting Drug Use and AIDS in Massachusetts

By April 1985, 5,540 or 17 percent of all AIDS ases reported nationally were among injecting drug sers (IDUs). As of April 1993, 65,778 individuals r 23% of the 289,320 AIDS cases reported ationally were among IDUs. This represents a early 12-fold increase in the number of cumulative eported cases among IDUs. By contrast, during this ame period there has been a seven-fold increase in he number of individuals reporting male to male sex s a mode of transmission. For specific reporting reas, the percentage of cumulative IDU cases is even reater. Forty-six percent of Connecticut's cases eported injecting drug use as the mode of ransmission as did 45 percent of New York City's ases.

The epidemiology of IDU-associated AIDS in assachusetts is similar to the national trend. Since e first case diagnosed in 1981, a cumulative total of ,441 AIDS cases have been reported among IDUs rough May, 1993. This figure represents 25 ercent of all reported AIDS cases in the state. hen reviewed by year of diagnosis, the trend of ases related to injecting drug use is striking. In 985, 14 percent of all AIDS cases diagnosed were tributed to injecting drug use; by 1992, this had sen to 38 percent. So far, 39 percent of all AIDS iagnoses in 1993 have been in IDUs (See Figure 1). 1992 for the first time, the total number of AIDS ses reported among IDUs (458) exceeded those agnosed among individuals reporting male to male x as their mode of transmission (454). This pattern continues into 1993 with a greater number of diagnosed AIDS cases attributable to injecting drug use (137) than to male to male sex (123).

Figure 1

MA IDU/IDU Related Cases and Female Cases By Select Urban Areas



According to a Health and Addiction Research, Inc. (HAR) study, several factors have fueled increased drug availability and use in Massachusetts. These factors include: well developed highway, public transportation and air transportation systems, coastal access for illegal drugs, a stagnant economy, and a reduction in funding for substance abuse services.

The HAR report gathers statistics by monitoring drug treatment clinic and emergency room visits, as well as drug related arrests. Based on these sources, the primary illegal drugs of choice in Massachusetts are cocaine and heroin. This includes both injecting and non-injecting use of these drugs. Based on 1992 drug treatment center statistics, heroin usage appears to have leveled while cocaine use continued to rise. The HAR report indicates that 19 percent of substance users reported heroin as their primary drug of choice, while 32 percent reported cocaine.

Inside:
- **Monthly Update...page 3**
- **Calendar.........page 4**

Next Month:
- **MA Seroprevalence Studies**

For case reporting of AIDS patients meeting the CDC definition, please notify AIDS Epidemiologists at (617)522-3700, ext. 482 or 478.

Though reduction in price and increase in the purity of available heroin has made inhalation a more common mode of administration, the majority of users still inject the drug (75%). In contrast, partially as a result of crack cocaine availability, the majority of cocaine users (64%) still report smoking as the preferred route.

Any analysis of drug usage and HIV infection is complicated by the many individuals who report multiple drug usage. According to the HAR report, thirty-eight percent of heroin users reported using cocaine in the last 30 days. In addition, a high percentage of cocaine and heroin users listed alcohol and marijuana as other commonly used drugs. This may increase their risk of HIV infection by impairing judgement and increasing unsafe sexual practices. Use of marijuana, amphetamines, barbiturates, and hallucinogens as primary drugs of choice continues to be relatively low in comparison to cocaine and heroin usage. (Primary usage of these drugs may be underestimated since usage may be less associated with drug treatment, ER visits, and arrests.)

The full impact of injecting drug use on HIV infection cannot be fully appreciated without considering individuals infected either directly or indirectly by the IDU. These include the sex partners of injecting drug users, and children born to a mother who is either an injecting drug user or has had sex with an infected IDU. These modes of transmission, combined with injecting drug use, represent 32 percent (2205) of all cumulative AIDS cases in Massachusetts. This trend is underscored among recently diagnosed individuals; 42 percent (507) of 1992 diagnosed cases and 44 percent (352) of 1993 cases reported either IDU or a related mode of transmission.

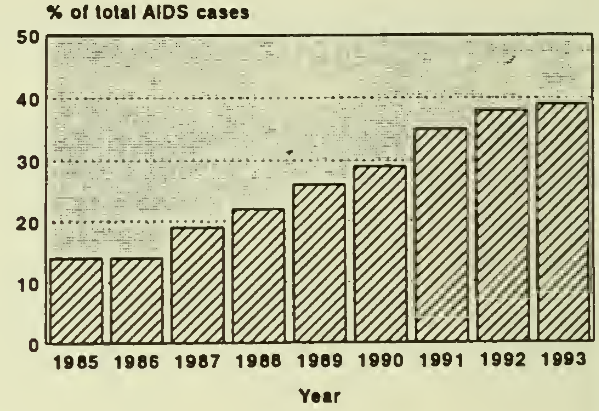
Of the IDU and IDU-related cases reported through May, 1993, 1522 were among males (69%) and 683 were among females (31%). As the number of AIDS cases among injecting drug users has risen, so has the number of cases among females. Nine percent of all cases diagnosed in 1985 were among women; by 1993 this percentage had risen to 21 percent. Among female cases, 48 percent were due to injecting drug use and 16 percent were acquired through sex with an injecting drug user.

Sixty-one percent of IDU and IDU-related cases (1336) were reported from communities of color, while thirty-nine percent (859) were reported among whites. The majority of cases, 55 percent (1218), were diagnosed in individuals between 30 and 39 years of age. Of 131 reported pediatric AIDS cases, 60 (49%) have been indirectly due to injecting drug use. Fifty percent (1101) of all reported IDU-related cases have died.

The prevalence of IDU and IDU-related cases varies greatly within Massachusetts. Not surprisingly, metropolitan Boston, the state's most populous area, has the greatest number of IDU and IDU-related cases (1155). However, only 27 percent of metropolitan Boston's AIDS cases reported these risks. This is a smaller percentage than most of the other urban areas in Massachusetts. Within the city of Boston, 711 (28%) of all cases reported were in IDU or related cases. About half of Boston's neighborhoods reported more than 30 percent of their AIDS cases as IDU or IDU-related. The New Bedford area had the greatest percentage of IDU or IDU-related AIDS cases with 63 percent; Springfield followed with 55 percent.

Figure 2

IDU AIDS Cases by Year in MA as a Percentage of Total Diagnosed Cases



Early in the AIDS epidemic it became clear that injecting drug users were at particularly high risk for HIV infection and development of AIDS. Unfortunately, what were projections a few years ago are now fact. Accessible drug treatment, safe-sex education, and clean needle use are needed to stem the growth of this AIDS population. In addition, an array of clinical and social services are necessary to help those already infected.

**All statistics related to patterns of drug usage in Massachusetts are derived from "Drug Use Trends in Greater Boston and Massachusetts" published by the Health and Addictions Research, Inc.*

Note to our readers: Only one issue of the newsletter will be printed for July and August and will be available in late July.

AIDS SURVEILLANCE SUMMARY

	Boston		Massachusetts		United States*	
Total Cases reported as of 6/1/93	2,596		6,947		253,448	
	No.	%	No.	%	No.	%
Residence						
City of Boston	2,596		2,596	37%		
Remainder of Boston SMSA**			1,706	25%		
Remainder of Massachusetts			2,299	33%		
SubTotal	2,596		6,601	95%		
Out of State Residence			346	5%		
Transmission Mode (Adults)	2,558		6,816		249,199	
Homosexual/Bisexual Male	1,420	56%	3,427	50%	142,626	57%
I. V. Drug User	630	25%	1,930	28%	57,412	23%
Homosexual IV Drug Users	90	4%	270	4%	15,899	6%
Hemophiliac	14	1%	124	2%	2,026	1%
Heterosexual	282	11%	661	10%	16,254	7%
Blood Transfusion Recipient	29	1%	144	2%	4,980	2%
Undetermined	93	4%	260	4%	10,002	4%
Transmission Mode (Pediatric)	38		131		4,249	
Mother with AIDS/at risk for HIV	35	92%	115	88%	3,665	86%
Hemophiliac	***		7	5%	188	4%
Blood Transfusion Recipient	***		9	7%	306	7%
Undetermined	***		***		90	2%
Gender						
Male	2,248	87%	5,933	85%	223,971	88%
Female	348	13%	1,014	15%	29,477	12%
Mortality Status						
Alive	1,057	41%	2,857	41%	81,558	32%
Dead	1,539	59%	4,090	59%	171,890	68%
Race/Ethnicity						
White	1,424	55%	4,464	64%	132,625	52%
Black	899	35%	1,519	22%	75,997	30%
Hispanic	254	10%	914	13%	42,199	17%
Other/Unknown	19	1%	50	1%	2,627	1%
Age Group (years)						
Under 13	38	1%	131	2%	4,249	2%
13 - 19	***		27	0%	946	0%
20 - 29	473	18%	1,336	19%	48,295	19%
30 - 39	1,341	52%	3,413	49%	115,918	46%
40 - 49	573	22%	1,526	22%	57,987	23%
Over 49	170	7%	514	7%	26,053	10%

*Total Cases reported as of Jan 1, 1993

** Refers to the Boston Standard Metropolitan Statistical Area

***Less than 5 reported

UPDATE:

In May, 306 AIDS Cases were reported to the AIDS Surveillance Program, 62% met the new definition

CALENDAR

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Strongest Link provides several support groups for individuals with HIV/AIDS and their caregivers. In addition, the organization provides case management, transportation, child care, education, information and referrals. Please call (508) 887-0090.

Study of IL-2 Fusion Toxin Patients who have not had opportunistic infections, are not taking anti-retrovirals and have CD4 counts between 300 and 600/mm^3 are needed for study of a potential early treatment for HIV infection. Contact hospitals directly - Boston City Hospital (617-534-5404), Beth Israel Hospital (617-735-5098) and Johns Hopkins Hospital (410-955-3422).

Multicultural AIDS Coalition is sponsoring a "Healing Ourselves" conference for HIV+ African American gay and bisexual men, June 25, 9:00 a.m. - 5:00 p.m., U. Mass., Harbor Point. To register, call 442-1622.

Neponset Health Center is offering free, walk-in anonymous HIV testing, 5:30 - 8:00 P.M., Mondays and Wednesdays. For information, call 282-3200.

Massachusetts Hospital Association is holding a conference on "Revisiting Tuberculosis: Control and Prevention in Hospitals" on June 24, from 9:00 a.m. to 3:30 p.m., at the Newton-Marriot. Call 272-8000 ext. 242 for information.

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AIDS NEWSLETTER

Vol. 9 No. ~~6~~ 7 Monthly Publication of the Massachusetts Department of Public Health July/August, 1993

Massachusetts gp 160 Vaccine Trial

Therapeutic vaccines have been studied and used for nearly a century. Recently they have been considered in the treatment of HIV infection. HIV vaccines have the potential to boost the immune system and consequently delay progression of symptomatic HIV infection. Glycoprotein (gp) 160, like other therapeutic vaccines, is being used with the intent of achieving this goal by boosting both the humoral and cellular immune systems. (MicroGeneSys, a Connecticut company, makes gp160 under the product name VaxSyn HIV-1.)

The Massachusetts Department of Public Health (MDPH) will soon be undertaking a new clinical trial of the gp160 vaccine. It will be the first HIV vaccine trial designed for people with low CD4 counts and the first time gp160 has been tested in conjunction with gamma interferon.

GP160 is a fragment of the material that covers the outer surface of the human immunodeficiency virus. When an individual is infected with HIV, antibody is produced against gp160. Scientists have been studying gp160 and related fragments of HIV for several years to see if they may be used as a preventive vaccine to immunize people not already infected. More recently, scientists have suggested that such a vaccine may also help people who are already infected with HIV. They believe that injections of gp160 to infected individuals may stimulate the immune system to build up its defenses against HIV.

Although CD4 counts generally decline over time, previous studies have shown that CD4 counts tend to remain steady in individuals who have received gp160 vaccine. In addition, some gp160 vaccine recipients have shown new antibody responses and other laboratory results that may indicate possible benefits.

Most previous trials of gp160 vaccine have been done on individuals with CD4 counts greater than 400. Neither its safety nor efficacy have yet been widely tested in individuals with CD4 counts of less than 400. It is not known whether persons with lower CD4 cell counts will respond sufficiently to the vaccine. Of the 140 who will be enrolled in the MDPH study, 90 will have CD4 counts of 200-400 at entry and the remaining 50 will have CD4 counts of less than 200.

Most studies of HIV therapies measure clinical benefits, such as fewer opportunistic infections, fewer symptoms, or longer survival. Although this study will monitor similar "clinical endpoints", the major outcome of interest is increased immune system activity against HIV as evidenced by new or increased antibody production. Specifically, tests will be done every three months to determine if the body is mounting a renewed response to the virus by enhanced production of anti-HIV antibodies.

The study is being conducted at 12 clinical sites around Massachusetts so that residents of all regions will have access. The number of participants in each region has been determined proportionately according to the number of reported AIDS cases. Enrollment will begin soon and proceed in two phases. First, 75 patients receiving care at the host facilities will be selected at random to enter the study. Later, there will be open enrollment of 65 persons randomly selected from a list of all interested persons who register with the central study office.

Inside:

- Monthly Update....page 3
- Calendar..........page 4

Next Month:

- MA HIV Serosurveys

For case reporting of AIDS patients meeting the CDC definition, please notify AIDS Epidemiologists at (617)522-3700, ext. 482 or 478.

The study is designed to last 15 months. When people enroll in the trial, they will receive an initial injection of gp160 vaccine and repeat doses once a month for six months. During the first six months, the amount of gp160 will be either (a) the standard dose (160 ug) now in use in other trials, (b) a higher dose (640 ug), or (c) the standard dose supplemented with an immune booster, gamma interferon. Initial dosage will be assigned at random; persons responding to their dose of vaccine will be given boosters with the same dosage at months 8, 10, 12. If after six months there is no immune response, then those participants (non-responders) will be switched to enhanced treatments. (See Table 1)

Table 1. Protocol for gp160 Trial

CD4 count 200–400/uL Random assignment	Group 1	Standard dose 160 ug
	Group 2	Standard dose + gamma interferon
	Group 3	4 x standard dose 640 ug
CD4 count under 200/uL	Group 4	
All Groups: Monthly injections, clinical assessment, immune response tests, evaluation of immune response at 6 months.		
Group 1 and Group 2	Responders:	Continue regimen, injections at months 8, 10 and 12
	Nonresponders:	Change to 4 x standard dose (640 ug) Injections at months 7, 8, 9, 10, 11, 12 and 14
Group 3 and Group 4	Responders:	Continue regimen, injections at months 8, 10 and 12
	Nonresponders:	Randomize into 2 groups: Group a – 8 x standard dose (1280 ug) Injections at months 7, 8, 9, 10, 11, 12 and 14 Group b – 4 x standard dose (640 ug) Injections at months 7, 8, 9, 10, 11, 12 and 14

Since this approach to treatment of HIV infection has never been used before, there is the possibility of adverse events. Hypothetically, the gp160 injections could stimulate the production of more virus or possibly cause neurological damage. In addition, the efficacy and safety of gamma interferon as an adjunct treatment has never been tested. It is possible that gamma interferon, like gp160, could theoretically stimulate the production of HIV. However, since it will be given only once a month, this is an unlikely possibility. Other side effects are similar to those attributed to many vaccines; localized pain or swelling at the site of injection and flu-like symptoms. Another consideration for participants in this trial is that they might be excluded from some current or future research studies.

Individuals who have received or are receiving any other HIV vaccines may not enroll in this study. Those who have received non-HIV vaccines can not enroll until four weeks after that injection. Participants are encouraged to continue the use of other antivirals during the trial. However, they should try to avoid changing their antiviral therapy during the first three months of participation in the gp160 vaccine study. Table 2 outlines the eligibility criteria for this study.

Table 2

Eligibility Criteria

- Both male and female Massachusetts residents are eligible.
- Participants must be at least 18 years of age
- CD4 counts <400
- Participants must be willing to participate monthly for at least 15 months.
- Pregnant and breast-feeding women may register for study but will be asked to wait until no longer pregnant or breast-feeding.

If you are interested in more information about enrollment, please call (617) 482-9485 and ask for the HIV Vaccine project line. This is all you need to do to register yourself as a potential study participant. All information will be kept completely confidential. Within several days you will receive additional information in the mail. The Massachusetts gp160 Vaccine Trial is being carried out in association with MicroGeneSys, Inc. and Wyeth-Ayerst Research Division.

AIDS SURVEILLANCE SUMMARY

	Boston		Massachusetts		United States*	
Total Cases reported as of 8/1/93	2,787		7,513		289,320	
	No.	%	No.	%	No.	%
Residence						
City of Boston	2,787		2,787	37%		
Remainder of Boston SMSA**			1,866	25%		
Remainder of Massachusetts			2,511	33%		
SubTotal	2,787		7,164	95%		
Out of State Residence			349	5%		
Transmission Mode (Adults)	2,747		7,380		284,840	
Homosexual/Bisexual Male	1,530	56%	3,663	50%	160,345	56%
I. V. Drug User	675	25%	2,116	29%	65,778	23%
Homosexual IV Drug Users	96	3%	296	4%	18,041	6%
Hemophiliac	15	1%	129	2%	2,519	1%
Heterosexual	305	11%	728	10%	19,178	7%
Blood Transfusion Recipient	30	1%	154	2%	5,384	2%
Undetermined	96	3%	294	4%	13,595	5%
Transmission Mode (Pediatric)	40		133		4,480	
Mother with AIDS/at risk for HIV	36	90%	117	88%	3,887	87%
Hemophiliac	***		7	5%	194	4%
Blood Transfusion Recipient	***		9	7%	315	7%
Undetermined	0		0		84	2%
Gender						
Male	2,401	86%	6,372	85%	254,726	88%
Female	386	14%	1,141	15%	34,594	12%
Mortality Status						
Alive	1,204	43%	3,239	43%	107,045	37%
Dead	1,583	57%	4,274	57%	182,275	63%
Race/Ethnicity						
White	1,532	55%	4,803	64%	150,247	52%
Black	967	35%	1,624	22%	88,238	30%
Hispanic	272	10%	1,038	14%	47,835	17%
Other/Unknown	16	1%	48	1%	3,000	1%
Age Group (years)						
Under 13	40	1%	133	2%	4,480	2%
13 – 19	***		28	0%	1,167	0%
20 – 29	511	18%	1,443	19%	55,120	19%
30 – 39	1,442	52%	3,711	49%	132,197	46%
40 – 49	615	22%	1,655	22%	66,933	23%
Over 49	178	6%	543	7%	29,423	10%
AIDS Case Definition						
1987 Definition	2380	85%	6357	85%		
1993 Definition	407	15%	1156	15%		

*Total Cases reported as of April 1, 1993

** Refers to the Boston Standard Metropolitan Statistical Area

***Less than 5 reported

UPDATE:

In July, 246 AIDS Cases were reported to the AIDS Surveillance Program, 65% met the new AIDS case definition.

CALENDAR

Massachusetts AIDS Discrimination Initiative (MADI) provides information and advocacy for people needing assistance in dealing with HIV-related discrimination. Call (800) AIDS-808.

Asymptomatic HIV+ Support Group held at the Fenway Community Health Center first three Wednesdays of every month from 7-9 p.m. Call Gail at (617) 267-0900 X283.

"Positive Directions" hosts a support group for gay couples of mixed HIV status. 1st and 3rd Monday of each month at Positive Directions, call (617) 262-3456. Positive Directions sponsors a peer support line (617) 247-7337 and (800) 794-7337.

The Support Group for family and friends of people with HIV at Neponset Health Center **will not meet** in August. The Support Group will resume Tuesday, September 14, at 6:30 P.M. For more information, call Jo at 282-3200.

Strongest Link provides several support groups for individuals with HIV/AIDS and their caregivers. In addition, the organization provides case management, transportation, child care, education, information and referrals. Please call (508) 887-0090.

Answer Plus+ is a free, confidential seminar to answer financial, legal, insurance, and job-related questions of people who have tested HIV +. The seminar will be held at AIDS Action Committee, 131 Clarendon St., from 6:30 to 8:30 P.M. on August 18. For more information, call 437-6200 ext. 216. Preregistration encouraged.

Boston Pediatric AIDS Project will be offering a series of free workshops entitled Living Legacy, September 1993 - March 1994. HIV-infected parents, their childrens' potential guardians and their case managers will be trained in how to plan for the childrens' futures. Workshops will take place at Dimock Community Health Center in Roxbury. Transportation to the site, lunch and child care will be provided. Call 442-6758 for more information.

Neponset Health Center is offering free, walk-in anonymous HIV testing, 5:30 - 8:00 P.M., Mondays and Wednesdays. For information, call 282-3200.

Boston Living Center holds a women's HIV/AIDS support group every Friday from 1:30 to 2:30 P.M. There will also be nutrition workshops on Wednesday, August 11 and August 18, 1:15 to 2:30 P.M., a healing circle on Tuesday, August 24, 1:15 to 2:30 P.M., and a seminar on Sex and HIV on Wednesday, August 25, 1:30 to 2:30 P.M. Call 236-1012 for more information.

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AIDS NEWSLETTER

Vol. 9 No. 8 Monthly Publication of the Massachusetts Department of Public Health September, 1993

UPDATE OF CDC HIV SEROSURVEYS IN MASSACHUSETTS

In response to a growing need for standardized and nationwide data about HIV infection, the federal Centers for Disease Control and Prevention (CDC) established a national sentinel surveillance system known as the CDC Family of HIV Seroprevalence Surveys in 1987. The Massachusetts Department of Public Health (MDPH), in conjunction with the Boston Department of Health and Hospitals (BDHH), instituted blinded seroprevalence surveys across the state as part of this family of serosurveys in 1988.

The objectives of blinded HIV seroprevalence surveys are: (1) to provide an estimate of the prevalence of HIV infection in subgroups of the population; (2) to assess risk factors associated with infection; and (3) to monitor trends in infection and risk behavior over time. Surveys are based in settings of significant public health concern, where the population is potentially at higher risk of exposure to HIV. Blinded seroprevalence studies in Massachusetts have been located in 7 sexually transmitted disease (STD) clinics, 3 tuberculosis clinics, 4 drug treatment centers, 3 women's health clinics, an adolescent health clinic, and 5 state and county correctional facilities. This article will review data from studies conducted in STD clinics and state prison facilities through December 1992.

HIV testing is performed on sera remaining after routine blood tests are performed. Demographic and HIV risk data are customarily collected from all clients; however, HIV testing is performed only after all personal identifiers have been removed from specimens. To ensure blinding, a percentage of samples are discarded before HIV testing, and data are reported by grouped categories so it is not possible to connect a particular result with a client. For this reason, blinded serosurveys are conducted only at locations that also offer voluntary HIV counseling and testing so that clients who want to know their HIV status have access to confidential testing. All sera remaining after routine diagnostic testing are included in the study, so the data are not biased by self-selection. All samples are tested by an HIV enzyme immunoassay (EIA), and if repeatedly reactive, are confirmed by a Western blot test. Testing is conducted by the HIV Laboratory at the State Laboratory Institute, MDPH.

Inside:
- **Monthly Update...page 3**
- **Calendar.........page 4**

Next Month:
- **HIV/AIDS and Gay Adolescents**

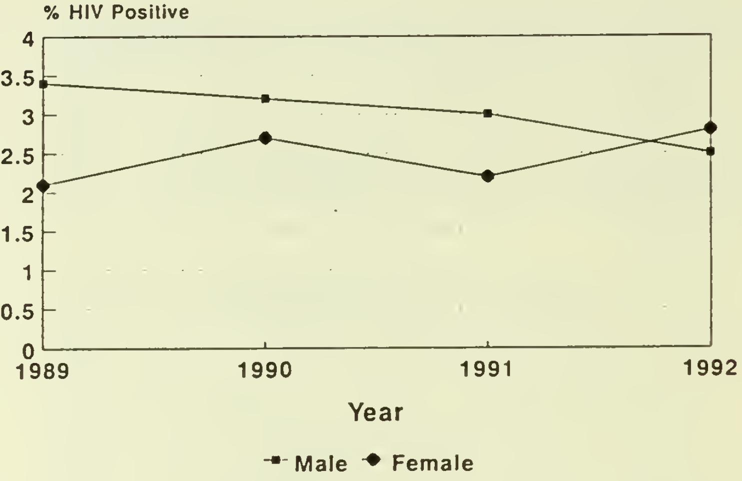
Sexually Transmitted Disease Clinics

STD clinics are important sites for HIV seroprevalence studies since behaviors associated with both STD and HIV transmission are similar. Since 1988, a total of seven publicly funded STD clinics, located in urban areas across the state, have participated in the survey. Three of these clinics have been part of the survey throughout the entire study period.

From September 1988 through December 1992, a total of 25,445 samples from STD clients were tested for antibody to HIV. The study population was predominantly male (71%) and under the age of 30 (64.5%). The racial composition was 43.9% Black, 38.7% White, and 9.7% Hispanic. Roughly three-quarters (78.6%) of the population reported multiple heterosexual partners or self-perceived low or no risk for HIV infection.

Of the 25,445 samples tested, 745 (2.9%) were positive. The percentage of positive samples from men (3.1%, 565/17,999) was greater than from women (2.4%, 177/7278). Over the course of the study period, however, HIV seroprevalence decreased among men but increased among women (Figure 1). Seropositivity increased with age category, and peaked in clients 35-39 years old (6.1%, 127/2081). Among clients under the age of 20, the HIV infection rate was 0.4% (12/3337); however, the syphilis rate in the same age group was 2.6% (85/3289), indicating a substantial level of unsafe sexual practices among adolescents attending these clinics. HIV seroprevalence was greatest in Hispanics (4.1%, 102/2462), followed by Blacks (3.5%. 391/1174) and Whites (2.0%, 199/9838). According to self-reported risk category, gay/bisexual males (21.0%, 115/547) had the highest rate of HIV infection; however, seroprevalence among gay/bisexual men has decreased over time, from 21.7% (28/129) in 1988 to 15.4% (16/104) in 1992. This accounts for a significant portion of the decrease in the annual rate observed among males. Seropositivity was 19.7% (36/183) among clients with an HIV-positive partner and 15.7% (134/855) among clients reporting a history of injection drug use. Though infection rates among people reporting multiple heterosexual partners (2.0%, 301/15,375) and low/no risk (1.3%, 58/4630) were relatively low compared to those of patients reporting the more "traditional" risk factors, they represent close to half (48.2%, 359/745) of all HIV infected people in the survey.

Figure 1. HIV Seroprevalence by Gender
7 Massachusetts STD Clinics



Correctional Facilities

Many persons housed in correctional facilities have committed drug-related crimes and are consequently at increased risk for exposure to HIV. Serosurvey data have been used to design education and prevention programs to reduce the risk of exposure to HIV. HIV serosurveys have been conducted in Massachusetts in a county jail, an awaiting trial unit, and three state prison facilities; the data presented here are from two men's and one women's state prisons, collected from March 1990 through December 1992.

The study population was 87.2% male and 12.8% female. Roughly half (50.2%) was under the age of thirty. Two-fifths (41.5%) of the population was White, 24.9% Black, and 18.1% Hispanic. Most individuals reported low or no risk for HIV (33.8%). However, inmates concerned about issues of privacy may not report their true level of risk for HIV. With respect to length of sentence, 38.1% of the study population was sentenced to a term less than three years, and 20.0% had sentences of 3-6 years.

Unlike the STD survey, the rate of HIV infection in women (12.8%, 163/1271) was greater than in men (7.3%, 631/8670) among prisoners. Seroprevalence was highest in inmates 35-39 years old (12.5%, 144/1154). Hispanics had an HIV seropositivity rate (13.7%, 246/1799) that was almost two times greater than either Blacks (7.1%, 177/2480) or Whites (6.1%, 250/4126). Among categories of self-reported risk behaviors, inmates with an HIV-positive partner had a seropositive rate of 45.9% (96/209). The rate of infection among injecting drug users was 20.1% (335/1668) (similar to the rate observed in the serosurvey in drug treatment centers).

Because blinded serosurvey data are standardized and are not biased by self-selection, results offer useful estimates of the prevalence of HIV infection among subgroups of the general population. In contrast, while AIDS case reporting provides information on risk factors, modes of transmission, and a means for projecting the number of people with AIDS, it can not accurately reflect current levels of HIV infection since the median time from infection with HIV to diagnosis with AIDS is roughly ten years. Data from voluntary counseling and testing programs give timely estimates of the number of people who have been recently tested for antibody to HIV and modes of transmission, but only reflect people who have chosen to be tested. Seroprevalence data can be used by public health workers to determine how to appropriately direct HIV prevention and treatment services. Agencies drafting requests for funding proposals (RFP) for HIV prevention and treatment services which seek to target groups at increased risk for HIV find blinded seroprevalence data useful for supporting their projects.

To request HIV seroprevalence data reports, please call the Massachusetts Department of Public Health at (617) 522-3700 ext. 190.

AIDS SURVEILLANCE SUMMARY

	Boston		Massachusetts		United States*	
Total Cases reported as of 9/1/93	2,840		7,666		315,390	
	No.	%	No.	%	No.	%
Residence						
City of Boston	2,840		2,840	37%		
Remainder of Boston SMSA**			1,905	25%		
Remainder of Massachusetts			2,572	34%		
SubTotal	2,840		7,317	95%		
Out of State Residence			349	5%		
Transmission Mode (Adults)	2,795		7,526		310,680	
Male/Male Sex	1,550	55%	3,710	49%	172,085	55%
Injecting Drug Use	699	25%	2,195	29%	73,610	24%
Male/Male Sex/I DU	96	3%	298	4%	19,557	6%
Hemophiliac	15	1%	130	2%	2,762	1%
Heterosexual	313	11%	749	10%	21,873	7%
Blood Transfusion Recipient	30	1%	154	2%	5,733	2%
Undetermined	92	3%	290	4%	15,060	5%
Transmission Mode (Pediatric)	45		140		4,710	
Mother with AIDS/at risk for HIV	41	91%	124	89%	4,121	87%
Hemophiliac	***		7	5%	202	4%
Blood Transfusion Recipient	***		9	6%	321	7%
Undetermined	0		0		66	1%
Gender						
Male	2,445	86%	6,487	85%	276,476	88%
Female	395	14%	1,179	15%	38,914	12%
Mortality Status						
Alive	1,241	44%	3,327	43%	121,056	38%
Dead	1,599	56%	4,339	57%	194,334	62%
Race/Ethnicity						
White	1,551	55%	4,882	64%	161,718	51%
Black	992	35%	1,667	22%	97,794	31%
Hispanic	281	10%	1,069	14%	52,531	17%
Other/Unknown	16	1%	48	1%	3,347	1%
Age Group (years)						
Under 13	45	2%	140	2%	4,710	1%
13 - 19	***		28	0%	1,301	0%
20 - 29	519	18%	1,470	19%	59,617	19%
30 - 39	1,468	52%	3,784	49%	144,056	46%
40 - 49	625	22%	1,693	22%	73,757	23%
Over 49	182	6%	551	7%	31,949	10%
AIDS Case Definition						
1987 Definition	2375	84%	6372	83%		
1993 Definition	465	16%	1294	17%		

*Total Cases reported as of July 1, 1993

** Refers to the Boston Standard Metropolitan Statistical Area

***Less than 5 reported

UPDATE:

In August, 157 AIDS Cases were reported to the AIDS Surveillance Program, 52% met the new AIDS case definition.

CALENDAR

Massachusetts AIDS Discrimination Initiative (MADI) provides information and advocacy for people needing assistance in dealing with HIV-related discrimination. Call (800) AIDS-808.

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Boston Pediatric AIDS Project will be offering a series of free workshops entitled Living Legacy, September 1993 - March 1994. The workshops are aimed at three groups: **case managers**, September 14 and 28, 8:30 a.m. - 2 p.m.; **HIV infected parents**, October 29 and November 4, 9 a.m.- 1 p.m.; and **potential guardians for children orphaned by HIV/AIDS**, February 24 and March 10, 9 a.m. to 1 p.m. Workshops will take place at Dimock Community Health Center in Roxbury. Transportation to the site, lunch and child care will be provided. Call 442-6758 for more information.

Neponset Health Center is offering free, walk-in anonymous HIV testing, 5:30 - 8:00 P.M., Mondays and Wednesdays. For information, call 282-3200.

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MC vol. 9 no 9

AIDS NEWSLETTER

Vol. 9 No. 10 Monthly Publication of the Massachusetts Department of Public Health October, 1993

HIV RISK IN YOUNG MEN WHO HAVE SEX WITH MEN

HIV infection is transmitted in primarily two ways: having unprotected sex with an infected individual or using an HIV-contaminated needle when injecting drugs. This is true for adolescents as well as for adults. Since adolescents are at a time in their lives when they are exploring their sexuality and/or experimenting with drugs, they are particularly vulnerable to infection. Adolescent HIV prevention efforts have focused on addressing and changing risky behaviors. However, the bulk of educational videos, brochures and outreach campaigns have pitched their prevention message to young people who are heterosexual. Often lost in the process of creating prevention compaigns is the recognition of gay, lesbian and bisexual young people. Many of these adolescents conceal their sexual identity from peers and adults because of social stigma and the threat of violence. As a result, current prevention messages may be inappropriate for their needs, particularly the needs of young men who have sex with men.

According to cumulative United States AIDS statistics from the Centers for Disease Control, 76% of 20-24 year old men with AIDS reported sex with men (MSM) as at least one of their risk behaviors (65% MSM, 11% MSM and injection drug use, IDU). Even among 13-19 year old men, an age group which includes a relatively large number of young men infected through contaminated blood products used for the treatment of hemophilia, 38% overall reported sex with men (33% MSM, 5% MSM and IDU).

Inside:

- **Monthly Update....page 3**
- **Calendar.........page 4**

Next Month:

- **Prophylactic Vaccine Trials**

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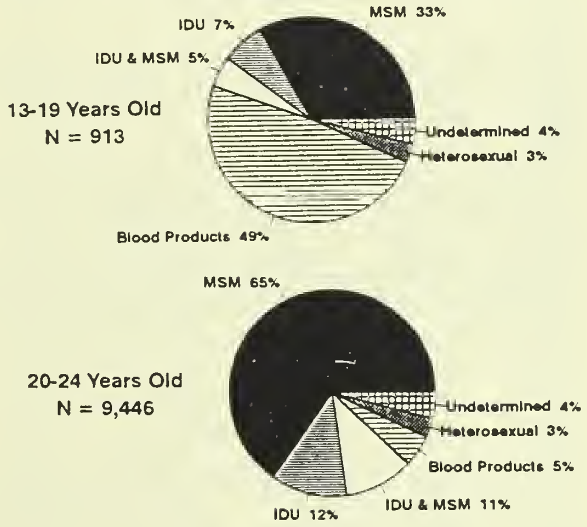
Although the relative proportion of young men with AIDS who report sex with men as a risk behavior is decreasing, it remains high. Among AIDS diagnoses recorded between July, 1992 and June, 1993, 69% of 20-24 year old men and 31% of 13-19 year old men reported sex with men as an HIV risk behavior (60% MSM, 9% MSM and IDU and 29% MSM, 2% MSM and IDU, respectively).

AIDS Cases in Male Adolescents and Young Adults, U.S. Cumulative Totals as of 7/93



Due to the lengthy clinical latency of HIV disease, AIDS diagnoses do not accurately indicate current HIV seroprevalence in this population. Recent serosurveys targeting young gay and bisexual men have unveiled a disturbing level of infection in this age cohort. The *Young Men's Survey* (Lemp et al, 1991) provided a unique opportunity to assess the serostatus of young men (age 17-25) who went to gay dance clubs in San Francisco. This survey found an overall HIV seroprevalence rate of 12%, with the highest rates among the younger men (age 17-22) and African-American men (22.9%).

A study confirming these rates was presented at the IX International Conference on AIDS in Berlin. This population sample involved 16-22 year old men from San Francisco and Berkeley (Givertz et al, 1993). The survey revealed a seroprevalence rate of 11% overall, with a rate of 40% among African-American men. In terms of age groups, the highest rates were among 20-22 year olds, at 13% HIV positive.

Another paper presented at that conference included an estimate of the annual incidence rate of HIV infection in San Francisco among men age 18-29 years old that was nearly double that of San Franciscan gay men in general (Winkelstein et al, 1993). Among some subsets of young men who have sex with men, prevalence rates are even higher. The CDC's 1990-1992 seroprevalence data from various settings found an HIV infection rate of 16% among young men in homeless and runaway centers who have had sex with men (Sweeney, 1993).

In many parts of the U.S. the incidence of unprotected anal intercourse appears to be considerably higher for young men who have sex with men than for older men. Givertz et al (1993) found high rates of unprotected anal intercourse in 16-22 year olds in the San Francisco Bay Area among African-American (56%), Latino (40%), Asian/Pacific Island (27%), and white (22%) men. Among young men who have sex with men, similar incidence rates of this risk behavior have been reported from Amsterdam (van den Hoek, 1993) and the Greater Boston area (AIDS Action Committee, 1991).

While young gay and bisexual men may resemble adult gay men in terms of certain sexual behaviors, they are quite unlike adult gay men in terms of the prevention education they have likely received. Gay and bisexual men who are currently older than thirty and have identified with the gay community have had the opportunity to be socialized into a peer group that has established safer sexual practices as the social norm. Intensive outreach and prevention strategies have been directed to adult gay and bisexual men over the past decade of the HIV epidemic. Further, most of these men have experienced the impact of AIDS directly upon their social networks, having seen friends, lovers, and co-workers test positive, develop symptoms, and receive an AIDS diagnosis. The impact of multiple losses on the behaviors of adult gay men cannot be underestimated.

On the other hand, young men who have sex with men have had a far different experience with the epidemic. The mass media has concentrated on the heterosexual population when presenting AIDS information to young people. School programs have largely attempted to "de-homosexualize" the disease in order to reach a larger audience of adolescents. Most young gay and bisexual men have not lost a friend to AIDS. The variety of social marketing efforts directed at adult gay and bisexual men have not been accessible to this younger cohort, as these efforts have utilized gay community institutions such as bars, newspapers, social/cultural organizations, and public sex environments to disseminate their prevention message.

Certain social factors also may compound the behavioral risk facing young gay and bisexual men. The lack of appropriate support services, school-based programs, and sensitive, confidential physical and mental health services add to the common sense of alienation and invisibility cited by many young people dealing with sexual identity issues.

One of the few papers from Berlin that evaluated various HIV prevention education models for this population found that a combination of social events and outreach efforts were more effective in reducing levels of risk behavior than workshops or other more formal educational efforts. The researchers felt that by drawing young men into peer designed and peer-led events that serve their social/personal needs, they were more likely to create a group norm for safer sexual activity (Cranston, 1991).

The epidemic of HIV infection among adolescents has arrived. Young men who have sex with men will continue to rank among the highest risk individuals. Prevention campaigns need to recognize and respond to this special level of risk.

AIDS SURVEILLANCE SUMMARY

	Boston		Massachusetts		United States*	
Total Cases reported as of 10/1/93	2,915		7,846		315,390	
	No.	%	No.	%	No.	%
Residence						
City of Boston	2,915		2,915	37%		
Remainder of Boston SMSA**			1,944	25%		
Remainder of Massachusetts			2,635	34%		
SubTotal	2,915		7,494	96%		
Out of State Residence			352	4%		
Transmission Mode (Adults)	2,870		7,705		310,680	
Male/Male Sex	1,593	56%	3,793	49%	172,085	55%
Injecting Drug Use	716	25%	2,255	29%	73,610	24%
Male/Male Sex/IDU	97	3%	299	4%	19,557	6%
Hemophiliac	15	1%	133	2%	2,762	1%
Heterosexual	319	11%	767	10%	21,873	7%
Blood Transfusion Recipient	30	1%	155	2%	5,733	2%
Undetermined	100	3%	303	4%	15,060	5%
Transmission Mode (Pediatric)	45		141		4,710	
Mother with AIDS/at risk for HIV	41	91%	125	89%	4,121	87%
Hemophiliac	***		7	5%	202	4%
Blood Transfusion Recipient	***		9	6%	321	7%
Undetermined	0		0		66	1%
Gender						
Male	2,511	86%	6,641	85%	276,476	88%
Female	404	14%	1,205	15%	38,914	12%
Mortality Status						
Alive	1,297	44%	3,457	44%	121,056	38%
Dead	1,618	56%	4,389	56%	194,334	62%
Race/Ethnicity						
White	1,594	55%	4,992	64%	161,718	51%
Black	1,018	35%	1,708	22%	97,794	31%
Hispanic	286	10%	1,096	14%	52,531	17%
Other/Unknown	17	1%	50	1%	3,347	1%
Age Group (years)						
Under 13	45	2%	141	2%	4,710	1%
13 - 19	***		28	0%	1,301	0%
20 - 29	535	18%	1,508	19%	59,617	19%
30 - 39	1,503	52%	3,873	49%	144,056	46%
40 - 49	643	22%	1,731	22%	73,757	23%
Over 49	188	6%	565	7%	31,949	10%
AIDS Case Definition						
1987 Definition	2392	82%	6425	82%		
1993 Definition	523	18%	1421	18%		

*Total Cases reported as of July 1, 1993

** Refers to the Boston Standard Metropolitan Statistical Area

***Less than 5 reported

UPDATE:

In September, 193 AIDS Cases were reported to the AIDS Surveillance Program, 52% met the new AIDS case definition.

CALENDAR

Massachusetts AIDS Discrimination Initiative (MADI) provides information and advocacy for people needing assistance in dealing with HIV-related discrimination. Call (800) AIDS-808.

Asymptomatic HIV+ Support Group held at the Fenway Community Health Center first three Wednesdays of every month from 7-9 p.m. Call Gail at (617) 267-0900 X283.

"Positive Directions" hosts a support group for gay couples of mixed HIV status. 1st and 3rd Monday of each month at Positive Directions. call (617) 262-3456. Positive Directions sponsors a peer support line (617) 247-7337 and (800) 794-7337.

The Support Group for family and friends of people with HIV meets every 2nd and 4th Tuesday at 6:30 P.M. at Neponset Health Center. For more information, call Jo at 282-3200.

Strongest Link provides several support groups for individuals with HIV/AIDS and their caregivers. In addition, the organization provides case management, transportation, child care, education, information and referrals. Please call (508) 887-0090.

Boston Pediatric AIDS Project will be offering a series of free workshops entitled Living Legacy, September 1993 - March 1994. Workshops aimed at **HIV-infected parents** will take place October 29 and November 4, 9 A.M. to 1 P.M. Workshops will take place at Dimock Community Health Center in Roxbury. Call 442-6758 for more information.

Therapeutic Vaccines for HIV Infection, a review of current and projected clinical trials of immunization in the treatment of HIV infection, will be held November 13, 8:30 a.m. to noon, at the Boston Marriot Cambridge Hotel. This forum is open to the public at no charge.

Neponset Health Center is offering free, walk-in anonymous HIV testing, 5:30 - 8:00 P.M., Mondays and Wednesdays. For information, call 282-3200.

AIDS NEWSLETTER
is a publication of the
AIDS Surveillance Program
October
1993

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AIDS NEWSLETTER

Vol. 9 No. 12 Monthly Publication of the Massachusetts Department of Public Health December, 1993

Therapeutic Vaccines for HIV Infection

In November's *AIDS Newsletter*, preventive vaccines for HIV infection were discussed. This issue will focus on the therapeutic use of HIV vaccines to block, or at least delay, progression to clinical AIDS in those already infected. Some of the problems that make it difficult to develop therapeutic vaccines are the same problems that complicate the development of a preventive vaccine.

It is now known that active, replicating virus is present throughout the asymptomatic period of HIV infection. When the immune system recognizes the presence of HIV, it begins to produce an immune response. Unlike immune responses to some other diseases, in which antibodies neutralize the invader and confer long-lasting protection, the immune response generated as a result of HIV infection is inadequate to control replication and spread of the virus. The rationale underlying the use of a vaccine as therapy is that it may elicit a more effective immune response to HIV than the usual host response to infection. This boost to the immune response of people infected with HIV may enable them to fight off the virus more effectively and remain healthier for a longer period of time.

Many characteristics of HIV make it difficult to develop a therapeutic vaccine. First, because the virus is highly diverse and mutates rapidly, a vaccine based on a single strain may not provide adequate protection against divergent HIV strains. Vaccines aimed at halting progression to AIDS may have to target different viral isolates in different individuals. Secondly, HIV can spread as free virus or via cell-to-cell transmission. Vaccines that rely on HIV envelope proteins to stimulate production of neutralizing antibodies may not adequately control cellular transmission. For this reason, it may be important to focus on the cell-mediated, cytotoxic T-lymphocyte response to destroy cells harboring HIV. Thirdly, vaccines derived from whole viruses, either live or attenuated, could recombine with the HIV DNA already present in seropositive persons and cause infection to worsen. Lastly, as was mentioned in the previous article, immune responses that correlate with effective fighting of HIV infection are not well understood. This lack of understanding makes it unclear as to which responses should be considered adequate markers in clinical trials of vaccine effectiveness. Questions need to be answered concerning whether neutralizing antibodies are important in control of infection and whether they correlate with altered disease progression, or if a cell-mediated immune response is necessary to destroy infected cells.

There are two major types of therapeutic vaccines under development: (1) envelope subunit vaccines (gp120, gp160) and (2) core protein vaccines (p24, whole-killed virus). In general, these vaccines have been found safe and somewhat effective in eliciting antibody responses, although insufficient time has elapsed to determine if any of these responses actually delay clinical progression of AIDS.

Inside:

•Monthly Update...page 3
•Calendar.........page 4

Next Month:

•Surveillance Summary for 1993

For case reporting of AIDS patients meeting the CDC definition, please notify AIDS Epidemiologists at (617)522-3700, ext. 482 or 478.

There is still no consensus as to which vaccine strategy might succeed; each has its proponents and its critics. As with preventive vaccines, predictions of success or failure must rely on evidence of efficacy in patients. There are several companies, as well as academic and government research laboratories, with candidate vaccines that are being tested for safety and effectiveness (see Table 1). However, it is difficult for individual companies to justify large scale efficacy trials (Phase III) when measures of efficacy have still not been made clear by the FDA.

No new vaccines for prevention or therapy have been developed in the last 24 months. Large, nation-wide comparative trials of one or more of the vaccines need to be done in order to get results that will direct further research. Until then, it is unlikely that there will be research and development of new approaches.

Information on clinical trials in New England that are currently enrolling patients is available from the Community Research Initiative of New England at (617)424-1524. Information regarding clinical trials nationwide is available through the National Institutes of Health at 1-800-TRIALS-A.

Table 1. Therapeutic Vaccine Strategies and Competing Companies

Company	Strategy	Development Stage
British Biotech. Group plc (UK)	p24-VLP virus-like particle vaccine; based on HIV core proteins genetically engineered in yeast cells	in Phase II
Genentech (CA)	Recombinant gp120 from IIIB strain of HIV with alum adjuvant	in extended Phase I
	Recombinant gp120 from MN strain with alum	in Phase I and II
Immune Response Corp. (CA)	Whole-killed virus with HIV core proteins only (no envelope) with incomplete Freund's adjuvant	recently completed Phase II/III
MicroGeneSys (CT)	Vaxsyn recombinant gp160 subunit vaccine made in baculovirus	in Phase II; Phase III began in Sweden in 2/93
Repligen (MA)	Synthetic, monovalent, cyclic peptide derived from V3 loop of MN strain; in emulsion with incomplete Freund's adjuvant	in Phase I
Therion Biologics (MA)	Particle-3B; particle-based vaccine containing HIV antigens	in preclinical dev.; plan to file IND in early '94
United Biomedical (NY)	Multicomponent vaccine containing 15 envelope peptides, lipopeptides based on envelope and core antigens, and a micro-particle delivery system	in Phase I/II
Viagene (CA)	Attenuated retrovirus vector that expresses whole gp160 gene from IIIB strain	in Phase I

Source:Genetic Engineering News, Nov, 1993

Note to Health Care Providers: In November, the new CDC AIDS Case Report forms were sent out to all infection control practitioners and physicians. If you did not receive these green forms, or if you did receive them and have questions about how to complete them, please call 522-3700 ext. 487.

AIDS SURVEILLANCE SUMMARY

	Boston		Massachusetts		United States*	
Total Cases reported as of 12/1/93	2,964		8,092		339,250	
	No.	%	No.	%	No.	%
Residence						
City of Boston	2,964		2,964	37%		
Remainder of Boston SMSA**			1,987	25%		
Remainder of Massachusetts			2,785	34%		
Subtotal	2,964		7,736	96%		
Out of State Residence			356	4%		
Transmission Mode						
Male Sex w/Male	1,617	55%	3,880	48%	183,344	54%
Injecting Drug Use	734	25%	2,360	29%	80,713	24%
Male/Male Sex & IDU	98	3%	309	4%	21,142	6%
Hemophiliac	16	1%	141	2%	3,165	1%
Heterosexual	321	11%	796	10%	24,358	7%
Blood Transfusion Recipient	32	1%	166	2%	6,311	2%
Perinatal	41	1%	129	2%	4,328	1%
Undetermined	105	4%	311	4%	15,889	5%
Gender						
Male	2,557	86%	6,843	85%	296,231	87%
Female	407	14%	1,249	15%	43,019	13%
Mortality Status						
Alive	1,251	42%	3,464	43%	134,860	40%
Dead	1,713	58%	4,628	57%	204,390	60%
Race/Ethnicity						
White	1,619	55%	5,130	63%	172,196	51%
Black	1,036	35%	1,747	22%	106,585	31%
Hispanic	288	10%	1,160	14%	56,818	17%
Other/Unknown	21	1%	55	1%	3,651	1%
Age Group (years)						
Under 13	45	2%	145	2%	4,903	1%
13 - 19	***		29	0%	1,415	0%
20 - 29	543	18%	1,552	19%	63,718	19%
30 - 39	1,524	51%	3,984	49%	154,934	46%
40 - 49	657	22%	1,802	22%	79,986	24%
Over 49	194	7%	580	7%	34,294	10%
AIDS Case Definition						
1987 Definition	2414	81%	6555	81%		
1993 Definition	550	19%	1537	19%		

*Total Cases reported as of October 1, 1993

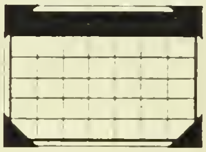
** Refers to the Boston Standard Metropolitan Statistical Area

***Less than 5 reported

UPDATE:

In November, 111 AIDS Cases were reported to the AIDS Surveillance Program, 47% met the new AIDS case definition.

CALENDAR



Volunteers needed: The AIDS Action Committee is looking for volunteers for a variety of activities. Volunteer Orientations will be held January 11 and January 27, 6-9 P.M., and January 22, 10 A.M. - 1 P.M., for those interested in finding out about working with clients, providing office support, doing community education and outreach, and more. For information, call 437-6200 ext. 283. For those interested in the Buddy Program (and older than 24), orientation and information sessions will be held December 28 and January 25, 7:30-8:30 P.M. For information call 437-6200 ext. 450. All workshops will be held at 131 Clarendon Street.

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Geiger Gibson and Mary Ellen McCormack Health Centers offer free, anonymous HIV testing. For information, call 288-1140.

HIV Dental Ombudsperson Program: Individuals with HIV/AIDS having trouble accessing or affording dental care can call (617) 534-4717 for help.

Ministerio "Aun Hay Esperanza": Queremos informar por estos medios que nuestro Ministerio "Aun Hay Esperanza" esta sirviendo a la Comunidad y ofrece servicios gratuitos a las personas que han adquirido el H.I.V. ofrecemos: consejeria espiritual, grupos de apoyo, ayuda familiar y otros servicios. Todo es completamente confidencial. Telefono: (617) 522-9440.

AIDS NEWSLETTER
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AIDS NEWSLETTER

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Vol. 10 No. 1 Monthly Publication of the Massachusetts Department of Public Health January, 1994

AIDS in Massachusetts - Ten Years of Surveillance

In 1983, AIDS became a reportable condition in Massachusetts, and since then the AIDS Surveillance Program of the Massachusetts Department of Public Health has been collecting demographic and clinical information on persons diagnosed with AIDS as defined by the federal Centers for Disease Control and Prevention (CDC). Over the past ten years, the epidemic that first occurred among gay men in urban areas has become an epidemic that affects all populations in all parts of the state. Numbers of cases related to injection drug use and heterosexual sex continue to increase, as do numbers of cases in communities of color, and among women and children. Due to improved prophylaxis and treatment, survival times of those with HIV-related disease are increasing, and there has been a decrease in incidence of some opportunistic infections, such as Pneumocystis carinii pneumonia (PCP). This article will describe several of the most striking trends in the epidemic.

Changes in the case definition have included more people with HIV disease as AIDS cases.

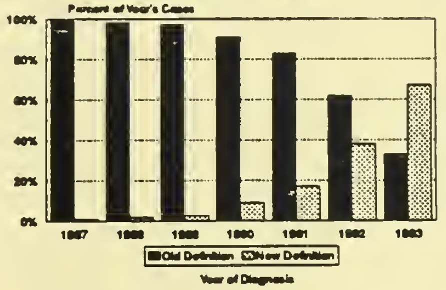
In order to more accurately describe the changing face of AIDS and to identify populations in need of services, the CDC's definition of AIDS has expanded over the past decade. Opportunistic infections, such as Kaposi's sarcoma (KS) and PCP, were the primary components of the case definition in 1983. This definition has been expanded to include more conditions that would accurately reflect the dimensions of the epidemic. In 1985, the HIV antibody test was licensed. In 1987, HIV dementia, wasting syndrome, and certain lymphomas were added as conditions in the AIDS case definition. A dramatic increase in cases of persons with HIV disease who met the AIDS case definition occurred at the beginning of 1993, when the case definition was expanded to include pulmonary tuberculosis, recurrent pneumonia, cervical cancer, and in particular, low CD4 counts (Figure 1). By the end of 1993, 20% of all diagnosed AIDS cases met the expanded 1993 case definition.

Inside:

Monthly Update...page 3
Calendar.........page 4

In April: Women and AIDS

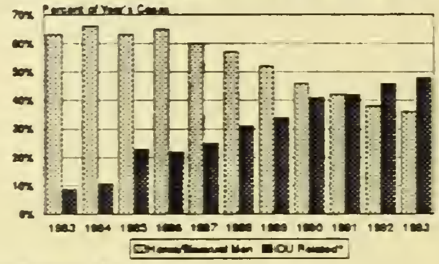
Figure 1. Massachusetts AIDS Cases
by Type of CDC Case Definition



Injection drug use-related cases continue to increase at a faster pace than any other risk behavior group.

In 1983, 9% of cumulatively diagnosed AIDS cases were attributed to injection drug use, while 63% of cases were attributed to male-to-male sex. Ten years later, cases attributed to male-to-male sex made up 48% of the cumulatively diagnosed AIDS cases, while cases attributed to injection drug use (including IDUs, their sex partners, and infected children born to IDU parents) made up 34% of all cases. Among pediatric cases, parental injection drug use was, and still is, the predominant risk factor. In 1991 the cases due to injection drug use equaled those due to male-to-male sex, and 1992 was the first year that the proportion of cases related to injection drug use was higher than the proportion related to male-to-male sex (Figure 2).

Figure 2. Trends in Massachusetts AIDS Cases by Transmission Category

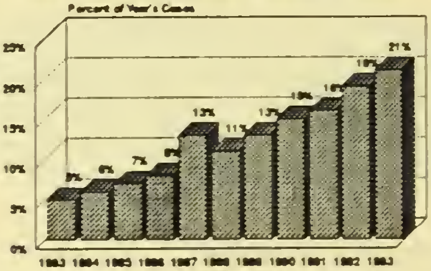


As of 1/1/94. MDPH AIDS Surveillance Program
* Includes IDUs, sexual partners of IDUs, and children born to IDU parents

AIDS cases among women continue to grow at a faster pace than among men.

In 1983, women made up only 5% of the state's cumulatively diagnosed AIDS cases. In 1993, they made up 16% of the total cases, and 21% of the year's cases. Cumulatively, 51% of the 1,220 adult female cases in Massachusetts attributed their infection to injection drug use. An additional 19% of women attributed their HIV infection to sexual contact with an injection drug user. In total, injection drug use is directly or indirectly responsible for 70% of adult female AIDS cases. Of the cases diagnosed in 1993 alone, the proportion of female AIDS cases that were injection drug use-related was 70% (Figure 3).

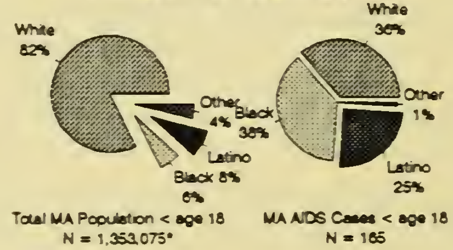
Figure 3. Trends in AIDS Diagnoses among Adult Female Massachusetts Cases



AIDS disproportionately affects communities of color.

In 1993, as in 1983, 63% of the cumulatively diagnosed AIDS cases were among whites. While only 11% of the general adult population is African American, Latino, or Asian, 30% of adult male AIDS cases and 59% of adult female cases are among communities of color (for the purposes of this comparison, adults are defined as those 18 years and older, although adult AIDS cases are usually defined as those over 13 years of age). For those under the age of 18, 18% of the general population is non-white, while 64% of AIDS cases in this age group are from communities of color.

Figure 4. Comparison of MA Population Under Age 18 to MA Pediatric AIDS Cases by Race



* 1990 U.S. Census

Other important trends help to describe the epidemic in Massachusetts. The number of cases attributed to heterosexual sex is growing at the pace of the rest of the epidemic. The epidemic is moving beyond large urban areas. More cases are being diagnosed on an outpatient basis. AIDS surveillance activities continue to be important because they facilitate description of the epidemic and its changes over time. The information can be used to target prevention and treatment services and to help in planning for the health care needs of HIV infected individuals.

The AIDS Surveillance Newsletter has played a major role in the distribution of surveillance information. It was originally targeted to health care providers. However, based on the mailing list and the phone calls from those who want to receive the newsletter, it is clear the reading audience includes a large number of students, consumers of HIV-related services, providers of social services, and members of the general public who want to stay informed about the epidemic in this state. In order to better meet the needs of our audience, we have decided to expand our newsletter, with the help of the MDPH AIDS Bureau, to include information about services and prevention, in addition to surveillance updates. This January newsletter is our last monthly newsletter - the expanded newsletter will be printed on a quarterly schedule starting in mid-April. Thank you for your continued interest in the newsletter and your valuable feedback.

For case reporting of AIDS patients meeting the CDC definition, please notify AIDS Epidemiologists at (617)522-3700, ext. 482 or 478.

AIDS SURVEILLANCE SUMMARY

	Boston		Massachusetts		United States*	
Total Cases reported as of 1/1/94	3,004		8,235		339,250	
	No.	%	No.	%	No.	%
Residence						
City of Boston	3,004		3,004	36%		
Remainder of Boston SMSA**			2,013	24%		
Remainder of Massachusetts			2,861	35%		
Subtotal	3,004		7,878	96%		
Out of State Residence			357	4%		
Transmission Mode						
Male Sex w/Male	1,635	54%	3,927	48%	183,344	54%
Injecting Drug Use	745	25%	2,415	29%	80,713	24%
Male/Male Sex & IDU	99	3%	313	4%	21,142	6%
Hemophiliac	16	1%	143	2%	3,165	1%
Heterosexual	317	11%	804	10%	24,358	7%
Blood Transfusion Recipient	39	1%	169	2%	6,311	2%
Perinatal	41	1%	130	2%	4,328	1%
Undetermined	112	4%	334	4%	15,889	5%
Gender						
Male	2,589	86%	6,951	84%	296,231	87%
Female	415	14%	1,284	16%	43,019	13%
Mortality Status						
Alive	1,268	42%	3,527	43%	134,860	40%
Dead	1,736	58%	4,708	57%	204,390	60%
Race/Ethnicity						
White	1,638	55%	5,207	63%	172,196	51%
Black	1,053	35%	1,779	22%	106,585	31%
Hispanic	292	10%	1,192	14%	56,818	17%
Other/Unknown	21	1%	57	1%	3,651	1%
Age Group (years)						
Under 13	45	1%	146	2%	4,903	1%
13 – 19			29	0%	1,415	0%
20 – 29	551	18%	1,576	19%	63,718	19%
30 – 39	1,546	51%	4,050	49%	154,934	46%
40 – 49	665	22%	1,843	22%	79,986	24%
Over 49	196	7%	591	7%	34,294	10%
AIDS Case Definition						
1987 Definition	2433	81%	6619	80%		
1993 Definition	571	19%	1616	20%		

*Total Cases reported as of October 1, 1993

** Refers to the Boston Standard Metropolitan Statistical Area

Blanks indicate less than 5 cases reported.

UPDATE:

In December, 164 AIDS Cases were reported to the AIDS Surveillance Program, 57% met the new AIDS case definition.

CALENDAR

Volunteers needed: The AIDS Action Committee is looking for volunteers for a variety of activities. A Volunteer Orientation will be held January 27, 6-9 P.M., for those interested in finding out about working with clients, providing office support, doing community education and outreach, and more. For information, call 437-6200 ext. 283. For those interested in the Buddy Program (and older than 24), orientation and information sessions will be held January 25 and February 22, 7:30-8:30 P.M. For information call 437-6200 ext. 450. All workshops will be held at 131 Clarendon Street.

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A Support Group for family and friends of people with HIV will meet for 8 weeks starting Thursday, February 3, at Neponset Health Center, 6:30 - 8:00 P.M. To register, call Jo at 282-3200.

Strongest Link provides several support groups for individuals with HIV/AIDS and their caregivers. In addition, the organization provides case management, transportation, child care, education, information and referrals. Please call (508) 887-0090.

Geiger Gibson and Mary Ellen McCormack Health Centers offer free, anonymous HIV testing. For information, call 288-1140.

HIV Dental Ombudsperson Program: Individuals with HIV/AIDS having trouble accessing or affording dental care can call (617) 534-4717 for help.

AIDS Law Workshop: A workshop for service providers about legal issues facing families of the 90s, Thursday, January 27, 9 A.M. to noon. Sponsored by the Gay and Lesbian Advocates and Dimock Community Health Center. Youth and Family Services boardroom, 1800 Columbus Ave., Roxbury. Call 617-426-1350 for more information.

STD Educational Series: This session will look at hepatitis B as a sexually transmitted disease. February 2, 1:30-2:45 P.M., with registration (required) at 1 P.M. State Laboratory Institute, Jamaica Plain. Call Christie Burke for more information - (617)522-3700 ext. 400.

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